**OLJABET HOSPITAL**

Please Note: PATIENTS NAME………………………………………………………………………………………………….…

1.All prescriptions to be re-written not later than **Monday** mid-day I/P NO……………............AGE:…………SEX: …………WARD……………………….BED……………

2. Use **red pen** for DDA DIAGNOSIS: ……………………………………………………………………………………………………………

3. Drug allergies ……………………………………………………………………….. PRESCRIBING DOCTOR……………………………………………………SIGN………………………… **TREATMENT SHEET**

ONCE ONLY PRESCRIPTION, STAT DOSES, PRE-MEDICATIONS

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| Date | Drug | Dose | Route | Frequency/Duration{FR/DU} | Name and signature | Time |
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| Date | Drugs | Dose | Route | FR/DU | Name and sign | DAY 1  AM PM | | | | DAY 2  AM PM | | | | | DAY 3  AM PM | | | | | DAY 4  AM PM | | | | DAY 5  AM PM | | | | DAY 6  AM PM | | | | | DAY 7  AM PM | | | |
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