

PRESCRIPTION

Prescriber's name (First, Last):	_____
Prescriber's college number:	_____
Prescriber's address:	_____
Prescriber's phone number	_____
Prescriber's fax number	_____

PATIENT NAME (First, Last):	_____
PATIENT ADDRESS:	_____
PATIENT PHONE NUMBER:	_____

DOB: <small>(MM/DD/YYYY)</small>		WEIGHT: <small>(KG)</small>		GENDER:		PHN#:		CS#:	
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Duplicate Prescription forms are required for medications in the Controlled Prescription Program

DATE <small>(MM/DD/YYYY):</small>	_____
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<p>All prescribed medication should include the following:</p> <p>Drug Name</p> <p>Directions</p> <p>Day Supply</p> <p>Quantity</p> <p># of Refill(s)</p>	
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ALLERGIES:	
Allergy list may be incomplete. Please review with patient or caregiver.	

_____ Prescriber's Signature	
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