Hospital Name
Address Line 1
Address Line 2
Phone: _____
Logo

Outpatient Prescription

Patient Name

_____
Birth Date

___ / ___ / _____
Medical Record No.

_____
Gender

_____
Visit Date

___ / ___ / _____

Prescriber Name

_____
Department

_____
License No.

_____

Medications

No.	Drug Name	Dosage/Form	Quantity	Instructions
1				
2				
3				

Date: ___ / ___ / _____

Signature & Stamp