

General Outpatient Prescription

Date:

Patient Information

Name

Age

Sex

Patient ID

Diagnosis

Allergies

Prescription

Drug Name	Strength	Dosage	Route	Frequency	Duration
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Instructions

Patient/Guardian Signature

Prescribing Physician Signature
