

# Infectious Disease Outpatient Prescription

Patient Name

Age

Sex

Date

Hospital/Clinic

Patient ID

Diagnosis

## Prescription

Drug Name	Strength	Dosage Form	Route	Frequency	Duration	Quantity	Instructions
<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 Notes

Prescribed by

Signature

