Hospital/Clinic Name: _____
Department: Psychiatry
Address: _____
Contact: _____
Date: _____
Prescription No.: _____

Psychiatric Outpatient Prescription

Patient Name: _____ **Age:** _____ **Sex:** _____

Patient ID: _____ **Diagnosis:** _____

#	Medication Name	Strength	Dosage	Route	Frequency	Duration	Notes

Special Instructions:

Patient's/Guardian's Signature:

_____
Doctor's Signature & Stamp:

_____
Name: _____
Registration No.: _____