Hospital Discharge Prescription

Patient Information

Name: _____

Date of Birth: ____/____/_____

Patient ID: _____

Address: _____

Contact Number: _____

Admission & Discharge Details

Admission Date: ____/____/_____

Discharge Date: ____/____/_____

Consultant: _____

Diagnosis: _____

Prescribed Medications

Medicine Name	Dosage	Frequency	Route	Duration	Instructions
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Special Instructions / Follow-up

Write any special instructions or follow-up notes here.

_____

Prescribing Doctor's Signature & Stamp

_____

Date