[CLINIC NAME]
[CLINIC ADDRESS]
[CLINIC PHONE]

Date: ____ / ____ / _____

Patient Information

Name: _____

Age: _____

Gender: _____

Address: _____

Contact: _____

Physician Information

Name: _____

License #: _____

Contact: _____

Prescription

Medication	Strength	Dosage & Instructions	Quantity	Days

Remarks / Notes

_____

_____

Physicianâ€™s Signature

Patientâ€™s Signature