Hospital/Clinic Name
Address: _____
Phone: _____
Date: ____ / ____ / _____
Prescription No: _____

Patient Information

Name: _____
Age: _____ **Gender:** _____
Patient ID: _____
Address: _____

Diagnosis

_____
_____

Prescription

No	Medication Name	Dosage	Frequency	Duration	Instructions
1					
2					
3					

Consultation Notes

_____
_____
_____

Next Appointment: ____ / ____ / _____
Follow-up: _____

_____

Doctor's Signature
(Name & Registration No.)

Note: This prescription is for psychiatric outpatient use only.