# Specialist Consultation Prescription

Dr. [Specialistâ€™s Name]
Specialty: [Specialty]
Clinic/Hospital: [Facility Name]
Phone: [Contact Number]

## Patient Information

Name: [Patient Name]
DOB: [DD/MM/YYYY]
ID/Record No.: [Patient ID]

Date: [Date]
Gender: [M/F]
Age: [Age]

## Diagnosis

[Diagnosis details or codes]

## Prescription

| Medication | Dosage & Route | Frequency | Duration | Notes |
|---|---|---|---|---|
| [Medication Name] | [e.g. 100mg, oral] | [e.g. once daily] | [e.g. 7 days] | [Instructions] |
| [Medication Name] | [Dosage] | [Frequency] | [Duration] | [Notes] |

## Recommendations / Next Steps

[Follow-up plan, referrals, investigations, or additional notes]

Date: _____

_____

[Dr. [Specialistâ€™s Name] â€“ Signature]
Medical Registration Number: [Number]