Doctor's Name

Qualification (eg.MBBS, MD)

Regn. No.: .... (ALLOPATHY)

Full Address, Contacts: (telephone No. E-mail etc.)

Date:

Name of the Patient..

Address*..

Age& Sex .... weight**

Rx

1) Name of Medicine***

Strength, dosage instruction, duration & total quantity ***

2) - do -
3) - do-

Doctor's signature
Stamp

DISPENSED

Date: .... Pharmacist: ....

Name of Pharmacy: ....
City

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*Postal address/E-mail/Mobile

Number **for Paediatric Patients ***

in capital letters only

Minimum size of the prescription blank should be (a) 14 X 21 cm (A5 size) & (b) XI x XI cm size.