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 ** .......................

1) Name of Medicine***

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

2) - do -

3) - do -

Doctor's signature

Stamp

Stamp of Medical Store

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*Postal address/E-mail/Mobile Number

**for Paediatric Patients

*** in capital letters only

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