PRESCRIPTION FORMAT

Doctor's Name : _____

Qualification : M.B.B.S., _____

Maharashtra Medical Council Reg. No. :(ALLOPATHY) _____

Full Address : _____

_____

_____

Telephone No.(Clinc): _____ Mobile No.: _____

Email Id : _____

Date : _____

Patient Name : _____

Address*: _____

_____

_____

Age : _____ Sex : _____ Weight** : _____

Rx

(1) Name of Medicine*** : _____

_____

_____

Strength, Dosage Instruction, Duration & Total Quantity***

(2) -do-

(3) -do-

Doctor's Signature &Date
Stamp

DISPENSED

Date : _____ Pharmacist : _____

Name of Pharmacy City : _____

_____

*Postal Address / E-mail /Mobile
Number** for Paediatric Patients***
in CAPITAL letters only

_____

Minimum size of the Prescription blank should be (a) 14X21cm (A5 size) & (b) XI x XI cm size.