

PRESCRIPTION PAPER

Date _____

Name of the health Institution: ADDIS PRIMARY CLINIC

Patient Full Name

Sex

Age

Weight

Card No.

Address: Region

Town

Woreda

Kebele

House No.

In Patient

Out Patient

Diagnosis (ICD Code No.)

Drugs Name, Strength dosage form, Dose Frequency, duration, Quantity How to use and Information	Price of each item (for dispenser use only)
<i>plan HCL</i>	
<i>negative p HCL</i>	
TOTAL	

Prescriber's

Full Name

Qualification

Registration

Signature _____

Dispenser's

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