Prescriber's Name
Clinic Address, phone number

___/___/___
Date of issue

_____
Patient's Name

_____
Patient's Address

_____ ___/___/___
Patient's Health Services Number Date of Birth

_____ _____ _____
Drug Strength Dosage form

_____
Directions for use

_____ _____
Total quantity numerical Total quantity written

_____ _____
Prescriber's signature Prescriber number
(_____)
(Supervising Physician for Medical Residents/Interns on Educational Register)

☐ No refills OR ☐Refills (except Narcotics) authorized 1 2 3 4 5 6 ☐other _____
at _____ days between refills
OR
☐Part fills authorized: Quantity per interval _____ at _____days between part fills

_____
Patient's signature (At pharmacy upon receipt of medication)