

Patient Instructions for Sample Drugs

Patient Name: _____ Date: _____

Dispensing Provider: _____

Medication: _____ Dose/Strength: _____
Quantity Given: _____ Lot #: _____

Patient Allergies:

Patient Instructions: (Dose, Route, Frequency, Special Instructions, i.e., Time of Day, With or Without Food, etc.)

Possible Side Effects or Adverse Reactions:

Other Written Information Provided: _____

Please call the office should you have any questions or concerns while taking this medication.

Name of Practice
Address
Telephone Number

The above information has been reviewed with me and I have been given a copy of these instructions.

Patient/Guardian Signature _____
Staff

____ Copy to patient
____ Copy to patient medical record