Patient Instructions Form

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