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