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