Provincial Health Services Authority
Province-wide solutions. Better health.

PRESCRIPTION

Prescriber's name (First, Last):	
Prescriber's college number:	
Prescriber's address:	
Prescriber's phone number	
Prescriber's fax number	

PATIENT NAME (First, Last):	
PATIENT ADDRESS:	
PATIENT PHONE NUMBER:	

DOB: (MM/DD/YYYY)		**WEIGHT:** (KG)		**GENDER:**		**PHN#:**		**CS#:**	

Duplicate Prescription forms are required for medications in the Controlled Prescription Program

DATE (MM/DD/YYYY):

All prescribed medication should include the following: **Drug Name** **Directions** **Day Supply** **Quantity** **# of Refill(s)**	

ALLERGIES:

Allergy list may be incomplete. Please review with patient or caregiver.

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Prescriber's Signature