



# COMMUNITY PRESCRIPTION SHEET

Surname: \_\_\_\_\_

Forename: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (affix sticky label here) NHI Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ General Practitioner: \_\_\_\_\_

Weight: \_\_\_\_\_ (Required only for children 12 years or under)

**ALLERGIES** This section must be completed before administration of any medication

Allergy/Reaction To (name drug or substance)	Type of Reaction

**PRESCRIPTION**

Drug	Dosage	Route	Frequency

The above dosage of \_\_\_\_\_ may be increased/decreased to/by

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

First administration in the community at (time) \_\_\_\_\_  
 In the event of an anaphylactic reaction, the nurse will carry out the procedures set down in the Community Health Management of Anaphylaxis Policy April 1997 (incorporated with WDHB Medicines Management Policy).

Doctor's Name Printed	Specimen Signature	Date
<b>Doctors Address</b>		

Expiry Date: \_\_\_\_\_