As Required Drugs

NAME: **WARD:**

Drug (approved name and form)	Dose	Route	Frequency and indication for use	Prescriber (Sign and PRINT Name)	Date	Pharmacy
IBUPROFEN with food	200-400mg	PO	PRN 4-6° MAX 1200mg 3200mg	SEEHER	19/8.	22/8/16 (S)

Date	19/8	21/8								
Time	18.20	1530								
Dose	400mg	400								
Route	PO	PO								
Sign	TB									

Drug (approved name and form)	Dose	Route	Frequency and indication for use	Prescriber (Sign and PRINT Name)	Date	Pharmacy

Date										
Time										
Dose										
Route										
Sign										

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Dose										
Route										
Sign										

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