MSD / SB14 / SPCL / …… / 20……

FORM FOR REQUISITION OF SPECIAL DRUGS

1. Name of the Patient :
2. Age :
3. Sex :
4. Address :
5. Hospital :
6. Clinic / BHT No :
7. Diagnosis :

NIC no of patient:
(Important)
Contact no of the patient :

Name of the drug	Strength	Frequency	Duration

8. Expected date of starting treatment/cycle :

…………………………...
Signature of the Consultant

…………………………...
Date

Recommendation of head of the institution:

Signature of the Head of the Institution: …………………………... Date: …………………..

If treatment with this drug is discontinued for any reason please inform Director MSD

For office use only: