Pharmacy Stamp

sample form

Please don't stamp over age box

Age

D.o.B

Title, Forename, Surname & Address

Number of days' treatment
N.B. Ensure dose is stated

NHS Number:

Endorsements

HOSPITAL PRESCRIBER

HP

QUANTITY PRESCRIBED
MUST NOT EXCEED 4 WEEKS

Prescriber's name and initials in block capitals

Signature of Prescriber

Date

For dispenser
No. of Prescns. on form

GENERAL SURGERY OPD
HOMERTON ROW
LONDON

E9 6SR

020 85105555

HOMERTON NHS TRUST

RQX20

RQX

HP

NHS

FP10NC0608

44786625346