

# Client Treatment Sheet

This sheet is to be completed by the prescribing doctor.

Client Name:

Date of Birth:

Name of Doctor:

Date	Prescribed Medication	Dose	Route	Frequency	Review	Doctor's	Discontinued	
	(use block letters)			(eg. 2 x daily, 4 hourly, 1x3 weekly)	Date	Signature	Date	Dr's Signature

## PRN and STAT Medication

Date	Prescribed Medication	Dose	Route	Circumstances & Frequency	Review	Doctor's	Discontinued	
	(use block letters)			of Administration	Date	Signature	Date	Dr's Signature

**Allergies (please print in red)**

