Appendix 1

COMMUNITY HOSPITAL CONTROLLED DRUG PRESCRIPTION

(TO BE DISPENSED BY PHARMACY, BORDERS GENERAL HOSPITAL ONLY)

COMMUNITY HOSPITAL	**Date**
Please note: patient name, CHI number and address must be handwritten even if addressograph label is affixed.	
Patient name	
CHI number	
Patient address	

Approved drug name *(include brand name where relevant)*	*Example* Zomorph			
Strength *(ensure strength and volume is stated for liquids or injections* eg. *5mg/5ml, 10mg/1ml strength per hour for patches* eg. *25mcg/hr)*	10mg			
Form (eg. *liquid, injection, patches, tablets, capsules* etc. *Indicate clearly when a modified release [M/R] preparation is required)*	MR capsules			
Dose and frequency *(as directed is not acceptable - dose must be stated)*	one twice a day			
Total quantity in words *(as total quantity of dosage units to be supplied ie volume in ml, number of tablets, capsules, ampoules, patches etc. Please request amps in multiples of 10 if possible)*	fourteen capsules			
Total quantity in figures *(as above)*	14			
Prescriber signature				
Prescriber name *(please print)*				
Contact number/Bleep				

BGH PHARMACY USE ONLY

Pharmacist clinical check			**Date**
Quantity dispensed			
Dispensed by			**Date**
Pharmacy final check by			**Date**