All India Institute of Medical Sciences Rishikesh Employee Health Scheme Drug Requisition Form (OPD)

Name of Patient:	Age:	Gender:
Name of Employee	Relationship to Employee:	Date
EHS No.	Phone No-	UHID
Diagnosis:		

S1.	Medication	(write	generic	Quantity		Mark	"B" if	Write justification if specific
No.	names only)			(maximum	of 3	writing	a brand	brand is needed &/or medicine
				months)				not included in hospital
								formulary

Signature of Consultant Name of Consultant:

Pharmacist Name & Signature: Dispensed Date: ____/___/___ Signature of EHS Officer-in-charge with Stamp