ALL INDIA INSTITUTE OF MEDICAL SCIENCES RISHIKESH Employee Health Scheme Drugs Requisition Form (IPD)

Age: -	Gender: -
Relation to Employee: -	UHID: -
Department: -	Ward: -
Phone Number: -	Date: -
	Relation to Employee: - Department: -

SI. No.	Medication (Write generic names Only)	Quantity	Mark "B" if writing a brand	Write justification if specific brand is needed & or medicine not included in hospital formulary

Signature of Consultant /Resident Name of Consultant / Resident

Pharmacist Name & Signature: Dispensed Date:

Above Medicine are not available On E-Hospital

Signature OF TL (Nursing) Name of TL (Nursing)