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

Name of Patient: Age Gender:

Name of Employee: Relationship to Employee: UHID:

Employee ID / EHS Num.:- Phone No.:

Diagnosis: Date-

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

Signature of Consultant
Name of Consultant:

Signature of EHS Officer-in-charge with Stamp

Pharmacist Name & Signature:
Dispensed Date: _____/_____/_____