Hospital PBS prescription form (page 1 of 3)
NB - not to scale

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Discharge location: _____ Ward/ clinic _____ Discharge date: / / Time: am/pm

Hospital prescription

UR number: _____ **Ward:** _____
Name: _____
Address: _____
_____ **DoB:** _____
Fill in or attach patient label

Patient's Medicare number

Pharmaceutical benefits entitlement or DVA number

Print patient's name _____

Tick appropriate box (one scheme only per form)

☐ Safety Net entitlement card holder ☐ Concessional or dependent, RPBS beneficiary or Safety Net concession card holder ☐ PBS ☐ RPBS ☐ Chemo Access

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	☎ Approval number if required

Example

Drug hypersensitivities
DO NOT LEAVE BOX BLANK
If patient has no allergies enter N/A in box

Prescriber's name: _____ Prescriber number: _____
Signature: _____ Date: _____
Pager number: _____ Clinical unit: _____

Please turn over for privacy note

I certify that I have received this medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading.

___/___/___ Date of supply _____ Patient or agent's signature _____ Agent's address

Patient or pharmacist copy

Hospital PBS prescription form (page 2 of 3)
NB - not to scale

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Discharge location: _____ Ward/ clinic _____ Discharge date: / / Time: am/pm

Hospital prescription

UR number:_____ **Ward:**_____
Name:_____
Address: _____
_____ **DoB:**_____
Fill in or attach patient label

Patient's Medicare number

Pharmaceutical benefits entitlement or DVA number

Print patient's name _____
Tick appropriate box (one scheme only per form.)

☐ Safety Net entitlement card holder ☐ Concessional or dependant, RPBS beneficiary or Safety Net concession card holder ☐ PBS ☐ RPBS ☐ Chemo Access

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	☎ Approval number if required

Example

Drug hypersensitivities
DO NOT LEAVE BOX BLANK
If patient has no allergies enter N/A in box.

Prescriber's name: _____ Prescriber number: _____
Signature: _____ Date: _____
Pager number: _____ Clinical unit: _____

I certify that I have received this medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading.

____/____/____ _____ _____
Date of supply Patient or agent's signature Agent's address

Medicare Australia / DVA copy

Hospital PBS prescription form (page 3 of 3)
NB – not to scale

B_HIC02076D.qxd 26/5/05 11:44 PM Page 1

Discharge location: _____ Ward/ clinic Discharge date: / / Time: am/pm

Hospital prescription

UR number:_____Ward:_____
Name:_____
Address: _____
_____ DoB:_____
Fill in or attach patient label

Patient's Medicare number

Pharmaceutical benefits entitlement or DVA number

Print patient's name _____

Tick appropriate box (one scheme only per form)

☐ Safety Net entitlement card holder ☐ Concessional or dependent, RPBS beneficiary or Safety Net concession card holder ☐ PBS ☐ RPBS ☐ Chemo Access

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	☎ Approval number if required

Example

Medical records copy

Drug hypersensitivities
DO NOT LEAVE BOX BLANK
If patient has no allergies enter N/A in box.

Prescriber's name: _____ Prescriber number: _____
Signature: _____ Date: _____
Pager number: _____ Clinical unit: _____

I certify that I have received this medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading.

____/____/____ _____ _____
Date of supply Patient or agent's signature Agent's address

Authority required items ONLY (refer to approved authority indications in *Schedule of Pharmaceutical Benefits*)
(Authority prescription applications 24 hour service PBS 1800 888 333 RPBS 1800 552 580)

Disease or purpose(s) for which benefit required or clinical justification for use of item _____

Next visit: GP/outpatients in _____
days/weeks/months

Patient's weight (paediatric): _____kg
Patient's age if child _____
Did an ADR occur during hospitalisation? _____
If YES, drug _____
Details _____

Pharmacy recommendation: _____

Medication chart done: Y / N
Medication counselling by: _____
Profile checked by: _____
Dispensed by: 1. _____ 2. _____
Handed out by: _____

4062 (10/05)