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

Hospital prescription

Auth Script No xxxxxxxx

Sample Hospital
99 High Street
ADELAIDE SA 5000

Tel: (05) 9999 9999
Provider no. 99999999H

Patient's Medicare number

1	2	3	4	–	5	6	7	8	9	–	1

Patient's Ref number 2

Pharmaceutical benefits entitlement or DVA number

UR number: 12345 **Ward:** B

Name: Jae Citizen

Address: 22 Smith Street

Adelaide SA 5000 **DoB:** 02/02/1970

Fill in or attach the patient label

Print patient's name Jae Citizen

Tick appropriate box (one scheme only per form)

PBS Safety Net entitlement cardholder ☐ Concessional or dependant, RPBS beneficiary or PBS Safety Net concession cardholder ☐ PBS ☑ RPBS ☐ Chemo Access ☐

Patient Weight 70kg

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	☎ Approval number if required
Atezolizumab injection	1200mg	Dose Every 3 weeks	1200mg	7		1234(5)

Drug hypersensitivities

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

N/A

Prescriber's name: Dr A Practitioner Prescriber number: 1234567

Prescriber's type: MP Pager number: 1 Clinical unit: 321

Signature: A Practitioner Date: 01 / 01 / 20XX

Turn over for privacy notice

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's or agent's signature ✍ Agent's address

PB041.1310

Patient or pharmacist copy