	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Kod Dokumen: HSAAS/FAR/BR213**
	PHARMACY COUNSELING FORM

To be filled by Doctor/Nurse

Please tick (√) at appropriate box

	OUT-PATIENT		**IN-PATIENT**

A. PATIENT'S PROFILE

Name :_____ Ward/Unit :_____

MRN No :_____ Bed No. :_____

Age :_____

Gender :_____

B. PURPOSE OF COUNSELING* *(Please tick (√) at appropriate box)*

	Injection Technique		Inhaler
	Eye / ear / nasal drop		Nasal spray
	Warfarin		Bowel cleansing procedure
	Multi drug therapy (eg : AntiTB)		Others

C. NOTES (Patient's diagnosis, medication name, dose and frequency)

_____

_____

_____

_____

_____

_____

_____

_____

Request by:

_____

(Signature & Stamp)

Name:

Date: