Client Name : **Doctor Name** : **Qualification** : **Reg No** :	

Date:	**Patient Reg.No:**
Name Of Patient	**Address**
Mobile No:	**Age:**
Sex:	

Rx

Sr. No	Product Name	Dossage/Frequency	No Of Days	Total Qty

Remark:

Special Instruction :

Dr._____
Qualifiaction:_____
Date:_____
Reg No:_____