HOSPITAL: _____ HOSP No. | | | | | | |

Dept. | Unit | Ward | Room | Bed | Name ----------Sex: M / F

C.I.D | | | | | | | | | | | | | |

Date of Admission: …… Doctor in charge…… Height……

Date of Birth …… Actual weight …… Dosing weight ……..

Age: …… BMI…… Baseline Serum Creatinine ……

Chief complaint/Diagnosis ……

Allergies ……

Past Medical History (PMH)

……

……

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PHARMACIST RECOMMENDATION FORM

Date	Current Medications:	Investigations

Date	Drug-related problems (DRP) and recommendations:

DATE	Drug-related problems and recommendations	Investigations

PHARMACIST RECOMMENDATION FORM