Central Manchester and Manchester Children's University Hospitals NHS Trust

Fax to 64104 when complete.
Original to be given to the patient

Dear District Nurse
Thank you for agreeing to administer:-

Drug .....

Route Of Administration .....

Dosage .....

How Often .....

How long for.....

Date Of 1st visit .....

Additional Information .....

Ward and Telephone .....

Patients Name ..... **G.P** .....

Address ....

....

....

Telephone ....

D.O.B .....

Doctors Signature .....

Doctors name printed .....

Position ..... **Bleep** .....

Date .....