dablapmeds
The shortcut to your chronic medication

PRESCRIPTION FORM

Date: D D / M M / Y Y New: ☐ Repeat: ☐

DISPENSER *(Trailer label if available)*
Patient counselled on the correct usage of medication and pick-up point (PUP) selection.

Signature: .....

Date Dispensed: D D / M M / Y Y

health
Department: Health
REPUBLIC OF SOUTH AFRICA

FACILITY DETAILS

Province: .....

Facility Name: .....

District: ..... Facility Contact No.: .....

Sub-district: .....

PATIENT DETAILS
(Complete in full. Ensure information is correct.)

DOB: D D / M M / Y Y

File No.: ..... Patient's Address: .....

Surname: .....

Name: .....

Age: ..... ID/Passport/Asylum No.: .....

Gender: .....

Weight: ..... Cell: .....

Language: ..... Alternate No.: .....

CLINICAL INFORMATION
(Authorised, registered prescriber to complete.)

- ☐ Acne Vulgaris
- ☐ Allergy
- ☐ Anaemia
- ☐ Angina Pectoris
- ☐ Anxiety/Panic Disorder
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Chronic Asymptomatic Hypokalaemia
- ☐ Chronic Kidney Disease
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Cardiac Failure
- ☐ Contraception: Hormonal Oral
- ☐ Depressive Disorders
- ☐ Depressive Disorder, Major
- ☐ Diabetes Mellitus, Type 2
- ☐ Diabetic Nephropathy
- ☐ Dry Eye
- ☐ Dyslipidaemia
- ☐ Eczema
- ☐ Epilepsy
- ☐ Gastro-Oesophageal Reflux Disease
- ☐ Gout
- ☐ Hormone Replacement Therapy
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Ischaemic Heart Disease, prevention of
- ☐ Isoniazid Preventive Therapy
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Pain, Chronic Neuropathic
- ☐ Pain, Chronic Non-Cancer
- ☐ Parkinson's Disease
- ☐ Pre-Exposure Prophylaxis (PrEP)
- ☐ Prostatic Hyperplasia, Benign
- ☐ Pruritus
- ☐ Psychosis, Chronic (Schizophrenia)
- ☐ Rheumatoid Arthritis
- ☐ Stroke: Secondary Prevention
- ☐ Treatment of Adverse Effects of Chronic Opioid Use: Constipation
- ☐ Other / Specify condition below:

Diagnosis ICD10: .....

PRESCRIPTION
(Use generic names only. Prescribe as per CCMDD formulary.)

	GENERIC NAME	STRE-NGTH	DOSAGE FORM	DIRECTIONS (Dosage & Frequency)	ROUTE	QUANTITY		EXPIRY DATE	REPEATS 6/12
						Prescribed	Dispensed		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

PRESCRIBER DETAILS
(Use stamp if available)

Name and Surname: .....

Designation: .....

HSPCA/SANC Reg No.: .....

Signature: .....

PATIENT CONSENT *(Mandatory field)*
I have received counselling and agree to participate in the programme for alternative distribution and pick-up of my chronic medication.

Signature: .....

Date: D D / M M / Y Y

COMMENTS

Next scheduled PUP collection

D D / M M / Y Y

Months Supply

☐ 1 Month ☐ 2 Months ☐ 3 Months

☐ 4 Months ☐ 5 Months ☐ 6 Months

Next clinic appointment date D D / M M / Y Y

☐ PUP ☐ Home Delivery

Selected PUP/Home Delivery Group Name:
Use the registered name (internal or external)

1. Proxy Name: ..... ID/PASSPORT/ASYLUM No.: ..... Cell: .....

2. Proxy Name: ..... ID/PASSPORT/ASYLUM No.: ..... Cell: .....