

PRESCRIPTION AUTHORISATION

Date:	
Patients Details:	
First Name:	Last Name:
Phone No:	
Date of Birth://	
Presenting Problem:	
Current Medications:	
Allergies:	
Student Practitioner Details	
Student Practitioner's Name:	
Student Practitioner's Signature:	
Student Phone No:	
CLINIC SUPERVISOR DETAILS	
Supervisor / Lecturer's Name:	
Supervisor / Lecturer's Signature:	
Supervisor / Lecturer's Phone No:	

NB: Incomplete prescriptions and forms without a legible supervisor's name and signature will NOT be made up. The Information contained herein will remain confidential.

Only Prescriptions signed by a Nature Care Supervisor or Lecturer will be accepted.



PRESCRIPTION AUTHORISATION
PRESCRIPTION:
(for herbal formulas state botanical name and amount of each ingredient)
Dose:
Bottle size: mls