

ALL INDIA INSTITUTE OF MEDICAL SCIENCES
Mangalagiri, Andhra Pradesh

Annexure-C

Employee Health Scheme Branded Drug Requisition Form

Name of the Patient:

Age/Gender:

EHS Employee ID:

UHID:

Diagnosis:

Department:

Date of request:

| Sl. No | Brand name | Generic name | Quantity | Justification if specific brand is needed or medicine not included in hospital formulary |
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Signature & Stamp

Treating Faculty

Signature & Stamp

HOD

Name & Signature

Pharmacist

Dispensed Date