



## TREATMENT SHEET

<b>CLIENT NAME:</b>	<b>D.O.B.</b>
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DATE	MEDICATION (please use block letters)	DOSE	ROUTE	WHEN & HOW OFTEN	START DATE	DATE CEASED	DOCTOR'S SIGNATURE

### PRN / STAT MEDICATION

DATE	MEDICATION (please use block letters)	DOSE	ROUTE	WHEN & HOW OFTEN	START DATE	DATE CEASED	DOCTOR'S SIGNATURE

### TOPICAL TREATMENT

DATE	MEDICATION (please use block letters)	DOSE	ROUTE	WHEN & HOW OFTEN	START DATE	DATE CEASED	DOCTOR'S SIGNATURE

<b>Signature:</b>	<b>Date:</b>
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**PLEASE NOTE: The treatment sheet must be completed when new medication is prescribed or dosages changed**