



Patient Name: **Please state full name**

Address: **Home address**

State:

Date of birth:.....

Weight (kg's) .....

Name of parent/guardian .....

Phone/Mobile no: **Patient or guardian**

**Item prescribed:**

Methylcobalamin SC injections 25mg/ml 0.3ml

**Dose:** Use 1 single dose syringe based on weight (64.5mcg per Kg) every X days

or as milligrams Mb12 per syringe every X days as required

**Quantity:** No. of days supply. (Syringes are supplied in multiples of 5)

**Repeats:** **Any repeat refills if required**

Signature: **of practitioner**

Date prescribed:

Reg no:

Name of practitioner:

Name of practice:

Address of practice:

Tel/fax/email of practice: