

Pharmacy First Consultation Details

Name			
Address			
Date of Birth	Male	<input type="checkbox"/>	<input type="checkbox"/>
	Female	<input type="checkbox"/>	<input type="checkbox"/>

Consultation			

Advice	<input type="checkbox"/>	Referral	<input type="checkbox"/>	Treatment	<input type="checkbox"/>
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Notes			

Recorded on PMR	<input type="checkbox"/>	Date	<input type="text"/>	Initials	<input type="text"/>
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