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| **Name:**  **DOB:** | **Address:** |

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| **Date** | **Name of cream prescribed** | **Directions: e.g. where to apply, how often to apply (2xdaily or PRN), amount required** | **Signature**  **of Health professional** |
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Supervisor/Senior to complete a E1 creams MAR/MSR chart or Pharmacy chart

Use the above information to complete the charts.

(If applicable complete a PRN protocol and PRN recording form)