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|  | **Drug Treatment Plan** |  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |  | **Week 1** | **Week 2** | **Week 3** | **Week 4** | **Week 5** | **Week 6** | **Week 7** | **Week 8** | **Week 9** | **Week 10** |
| **Drug Name** | **Time** |  |  |  |  |  |  |  |  |  |  |
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| **pm** |  |  |  |  |  |  |  |  |  |  |
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|  | **am** |  |  |  |  |  |  |  |  |  |  |
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| **pm** |  |  |  |  |  |  |  |  |  |  |
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| **pm** |  |  |  |  |  |  |  |  |  |  |
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| **pm** |  |  |  |  |  |  |  |  |  |  |
| **Notes: Weight:****Name of Prescribing Doctor: Signature: Date:**  |