



**DR. GARY BIRDSALL
MEDICAL CLINIC, LLC**

PATIENT INJECTIONS SHEET

Name: _____ **MEDICATION ORDER:** _____

DOB: _____ **DX:** _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____

DATE: _____ MEDS: _____ SITE: _____ INT. _____