

Patient Name: \_\_\_\_\_

ECFTA Chart #: \_\_\_\_\_

Date: \_\_\_\_\_

CCFTA Chart #: \_\_\_\_\_

**MEDICATION RECONCILIATION LIST**

**Current medications (please list medications, including dose and how often taken) and over the counter medications**

**No regular medications**

_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	time(s) per day
_____	time(s) per day	_____	as needed
_____	time(s) per day	_____	as needed
_____	time(s) per day	_____	as needed
_____	time(s) per day	_____	as needed

**Eye Drop Schedule—If you go home with your eye patched you will start your drops tomorrow.**

<b>Vigamox</b>	one drop	right eye	left eye	3 times a day	4 times a day
<b>Nevanac</b>	one drop	right eye	left eye	3 times a day	4 times a day
<b>Prednisolone Acetate 1%</b>	one drop	right eye	left eye	3 times a day	4 times a day Every 2 hours while awake
<b>Atropine</b>	one drop	right eye	left eye	2 times a day	3 times a day

**Erythromycin Ointment** \_\_\_\_\_ times a day apply to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_