LAKESHORE EYE SURGERY CENTER

Surgeon: _____

Name: _____

MRN: _____

DOB: _____ Age: _____

Date of Surgery: _____

PACU MEDICATION LIST OUTPATIENT DISCHARGE MEDICATION INSTRUCTIONS

ALLERGIES: ❒ No known allergies **Latex Allergy:** ❒ Yes ❒ No

ALLERGY (drug)	Reaction	Allergy (drug)	Reaction

CURRENT *PRESCRIPTION* MEDICATIONS

NAME OF MEDICATION (Print)	Dose	How Often	Continue After Discharge	Stop Taking After Discharge

HERBALS, VITAMINS, SUPPLEMENTS, NON-PRESCRIPTION DRUGS

NAME OF MEDICATION (Print)	Dose	How Often	Continue After Discharge	Stop Taking After Discharge

Sig. of person filling out form: _____ Date: _____ Information obtained from: _____

NEW MEDICATIONS OR NEW DOSAGES YOU SHOULD TAKE AFTER DISCHARGE

MEDICATION - DOSE	ROUTE	HOW OFTEN	COMMENTS
	❒ Eye Drops ❒ _____	Every ____ hrs. ___ x/day	
	❒ Eye Drops ❒ _____	Every ____ hrs. ___ x/day	
	❒ Eye Drops ❒ _____	Every ____ hrs. ___ x/day	
	❒ Eye Drops ❒ _____	Every ____ hrs. ___ x/day	
	❒ Eye Drops ❒ _____	Every ____ hrs. ___ x/day	

Signature of Patient/Responsible Person: _____ Date: _____

Nurse Signature: _____ Date: _____ Physician's Signature: _____ *540 – 6/15/09*