SOUTHEASTERN RETINA SPECIALISTS

Today's Date: _____

PRESCRIPTION, OVER THE COUNTER AND SUPPLEMENT MEDICATION LIST

Patient Name: _____ **DOB:** _____

Pharmacy Name & Phone #: _____

Drug Allergies: _____

Primary Care Physician Name & Phone #: _____

DRUG NAME (Please print)	**DOSAGE**	**FREQUENCY**	**ROUTE** (Oral, Nasal, IM, Drops, Topical, Suppository)	**ADD / DC DATE**

***** If additional space is needed, please print an additional sheet or request one from the front desk *****

----------FOR OFFICE USE ONLY----------

Updated By:	**Date:**	**Updated By:**	**Date:**	**Updated By:**	**Date:**