Tache Pharmacy
400 Tache Avenue
Winnpeg, MB R2H 3C3
Phone: 204-233-3469 Fax: 204-231-1739

Patient Name:	**DOB:**
Patient Address:	**PHIN:**
Patient Phone:	**Date:**

Atropine Eye Drops

***Please note we can make other strengths**

M: ☐ Atropine 0.05% Ophthalmic Drops

☐ Atropine 0.02% Ophthalmic Drops

☐ Atropine 0.01% Ophthalmic Drops

☐ Atropine ____% Ophthalmic Drops

Quantity: ☐ 5mL ☐ 10mL

Sig: Instill 1 drop into each eye daily at bedtime OR _____

Refill: 1 2 3 (Please circle) _____ (other)

Prescriber Name: (Please print)	
Address:	
Phone:	
Signature:	