

Tache Pharmacy
400 Tache Avenue
Winnipeg, 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:	

Prescription Certification: This prescription represents the original of the prescription. The pharmacy addressee noted above is the only intended recipient and there are no other. The original prescription has been invalidated and securely filed and it will not be transmitted elsewhere at another time.
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