Patient: ______________________________ Cataract Surgery Medication Instructions For RIGHT / LEFT Eye

Medication Generic Equivilant	Pred Forte Prednisolone Acetate	Ocuflox Ofloxacin	Zymaxid Gatifloxacin	Compound Drop Pred-Gati-Brom
Directions - 1 DROP	**Anti-Inflammatory**	**Antibiotic**	**Antibiotic**	**Anti-Inflam/Antibiotic/Pain**
3 Days Before Surgery ______/______	① ② ③ ④	**None**	**None**	**None**
2 Days Before Surgery ______/______	① ② ③ ④	**None**	**None**	**None**
1 Day Before Surgery ______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
Surgery Day ______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
Begin WEEK 1 ______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
______/______	① ② ③ ④	① ② ③ ④	① ② ③ ④	① ② ③ ④
Begin WEEK 2 ______/______	① ② ③	**STOP**	**STOP**	① ② ③
______/______	① ② ③	***NOTES**		① ② ③
______/______	① ② ③			① ② ③
______/______	① ② ③	*SHAKE BOTTLES BEFORE EACH USE.		① ② ③
______/______	① ② ③			① ② ③
______/______	① ② ③			① ② ③
______/______	① ② ③			① ② ③
Begin WEEK 3 ______/______	① ②			① ②
______/______	① ②	*When Using Multiple Eyedrops, Please Wait At Least 5 Minutes Between Each Different Eyedrop.		① ②
______/______	① ②			① ②
______/______	① ②			① ②
______/______	① ②			① ②
______/______	① ②			① ②
______/______	① ②			① ②

Begin WEEK 4 _____/_____	①		①
_____/_____	①	* If You Need Refills, Please Call Your Pharmacy. *Questions or Concerns, Please Call Michelle @ 520-576-5110 x 2	①
_____/_____	①		①
_____/_____	①		①
_____/_____	①		①
_____/_____	①		①
_____/_____	①		①