My Optimus Medication Tracker

In order for Optimus Health Care, Inc. to provide the best quality care to you, it’s important that your healthcare provider is aware of all prescription and over the counter medication you take, including herbal supplements. By carrying a complete, up-to-date list of your home medication with you at all times, you can help your healthcare provider develop the best plan of care and treatment recommendations for you. Medication errors are a primary cause of complications in healthcare. Emergencies can occur and this information is critical for healthcare providers to avoid adverse reactions related to medications.

By using a current medication list and keeping it updated, you:

1. Keep track of your medications to reduce confusion and save time.
2. Improve MEDICATION SAFETY. Medication interactions and duplications can be detected and corrected.
3. Improve communication. Provide physicians with a current list of ALL of your medications. The list lets you and/or family members know exactly what medications are to be taken and when.

In addition to prescribed medication, it is also important to include such things as:

- Eye drops
- Inhalers/Nebulizers
- Creams/Ointments
- Oxygen
- Contraceptives
- Patches that contain medication
- Over-the-counter medication: examples include Aspirin, antacids, vitamins, laxatives, etc.
- Dietary and herbal supplements: examples include Gingko Biloba, St. John’s Wort, Green Tea, etc.
  - Note: When taking herbal supplements, please notify your physician)

We also recommend your designated emergency contact person keep a current list of your home medications. This will help your healthcare provider to better care for you in the event of an emergency.

**REMEMBER TO UPDATE YOUR MEDICATIONS- Mark out medications that are discontinued. Add new medications started.**
My Optimus Medication Tracker

Name: _______________________________________________ Primary Physician: __________________________

Emergency Contact: __________________________________ Relationship: ___________________________ Phone: __________________________

Drug or other Allergies: ________________________________________________________________

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Dosage, frequency, time</th>
<th>Prescribing Doctor</th>
<th>Refill Date</th>
<th>Notes</th>
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