PRESCRIPTION

STERILE VET EYE DROPS ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

MEDICATIONS

☐ Acetylcysteine Eye Drops	◯ 5%	◯ 10%	◯ 15%			◯ 5ml	◯ 10ml ◯ 15ml
☐ Chloramphenicol 1% Eye Drops						◯ 5ml	◯ 10ml ◯ 15ml
☐ Cidofovir 0.5% Eye Drops							2ml
☐ Cyclosporin	◯ 1%	◯ 2% Eye Drops		◯ Aqeuous	◯ MCT Oil	◯ 5ml	◯ 10ml ◯ 15ml
☐ Demecarium Bromide	◯ 0.125%	◯ 0.25%					5ml
☐ Diclofenac 0.1% Eye Drops							5ml
☐ EDTA eye drops	◯ 1%	◯ 2%	◯ 3%			◯ 5ml	◯ 10ml ◯ 15ml
☐ Fluconazole 0.3% Eye Drops							5ml
☐ Fluconazole 1% / DMSO 10% Eye Drops							5ml
☐ Flurbiprofen	◯ 0.03%	◯ 0.04% Eye Drops				◯ 5ml	◯ 10ml ◯ 15ml
☐ Idoxuridine 0.1% Eye Drops						◯ 5ml	◯ 10ml ◯ 15ml
☐ Tacrolimus	◯ 0.02%	◯ 0.03%		◯ Aqueous	◯ MCT Oil	◯ 5ml	◯ 10ml ◯ 15ml
☐ Tobramycin _____%						◯ 5ml	◯ 10ml ◯ 15ml
☐ Vitamin A 10000IU/ml						◯ 5ml	◯ 10ml ◯ 15ml
☐ Pilocarpine 0.1%						◯ 5ml	◯ 10ml ◯ 15ml
☐ Other						◯ 5ml	◯ 10ml ◯ 15ml

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____