Patient Name _____D.O.B_____ Date _____
Address _____ Phone # _____
Allergies _____

Sterile Ophthalmic Preparations – To be compounded

PLEASE CHECK REQUESTED COMPOUNDED PRESCRIPTION (notation of strength, quantity, directions for use may be required)

	Strength	Quantity
◯ Autologous eye drops	20%	Quantity sufficient for 6-month supply
◯ Blood draw - required (Quantity sufficient to prepare)	30% 40% 50% (Please circle one)	Quantity sufficient for 45-day supply
◯ Vancomycin O/S	25mg/ml **(2.5%)** 50mg/ml **(5%)**	10ml
◯ Gentamicin O/S	13.6mg/ml	7ml
◯ Tobramycin O/S	13.6mg/ml	7ml
◯ Amikacin O/S	50mg/ml	10ml
◯ Cefazolin O/S	50mg/ml	10ml
◯ Ceftazidime O/S	50mg/ml	10ml
◯ Amphotericin B O/S	1.5mg/ml	10ml
◯ Voriconazole O/S	10mg/ml	10ml
◯ Mitomycin C O/S	0.2mg/ml	1ml
◯ Edetate Disodium O/S	0.37% **(0.01M)** 1.7% **(0.05M)**	2ml
◯ Glycerin O/S	50% 80%	5ml
◯ Acetylcysteine O/S	10%	Quantity sufficient for 28-day supply
◯ Fluorouracil (5-FU) O/S	10mg/ml	5ml x 4 bottles Quantity sufficient for 4 cycles
◯ Low Dose Atropine O/S	0.01% 0.05%	Quantity sufficient for 30-day supply

****Refills 1 2 3 4 5 prn zero**

Sig: Instill __1___ gtts ___OU(both) ___OS (Left) ____OD (Right) _____ x Daily

Sig (Alternative): _____

Date/time of scheduled surgical procedure (if applicable): _____

Prescriber name/signature: _____

Clinic Phone # _____

Patient Name _____D.O.B_____ Date _____
Address _____ Phone # _____
Allergies _____

Sterile Ophthalmic Preparations – To be compounded

PLEASE CHECK REQUESTED COMPOUNDED PRESCRIPTION (notation of strength, quantity, directions for use may be required)

NOTE: Compounded formulations listed below are for intravitreal injections only. Additional 0.05mls overfill provided for drug loss within hub/lumen of needle.					
◯ Vancomycin INJ	1mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Ceftazidime INJ	2.25mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Dexamethasone INJ	0.4mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Clindamycin INJ	1 mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Fluorouracil INJ	5mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Methotrexate INJ	0.4mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified licensed medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**

****Refills 1 2 3 4 5 prn zero**

Sig (Alternative): _____

Date/time of scheduled surgical procedure (if applicable): _____

Prescriber name/signature: _____

Clinic Phone # _____