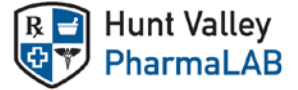


STAT DROPS™

PRESCRIBING SHEET



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DR. _____

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Phone: _____

Email To: RX@HVPCC.COM

Fax To: 410-666-7253

PATIENT INFORMATION

Patient Name:	DOB:	Gender:	M	F
Address:	Phone:			
City/ST/Zip:	Email:			

All Preparations Are **PRESERVATIVE FREE** Unless Otherwise Specified.

CHECK BELOW	ANTIBIOTICS			QUANTITY (ML)
<input type="radio"/> Vancomycin (<i>circle one</i>)	25 mg/mL	50 mg/mL		10 mL
<input type="radio"/> Tobramycin (<i>circle one</i>)	3 mg/mL	13.3 mg/mL (<i>Fortified</i>)		10 mL
<input type="radio"/> Gentamicin (<i>circle one</i>)	3 mg/mL	13.3 mg/mL (<i>Fortified</i>)		5 mL
<input type="radio"/> Ceftazidime	50 mg/mL			10 mL
CHECK BELOW	ANTIFUNGALS			QUANTITY (ML)
<input type="radio"/> Amphotericin B (5 mg/mL)				10 mL
<input type="radio"/> Voriconazole 1%				10 mL
CHECK BELOW	DRY EYES			QUANTITY (ML)
<input type="radio"/> Cyclosporine 1% with Artificial Tears				10 mL
<input type="radio"/> Glycerin 40% Solution				15 mL
<input type="radio"/> NovoTears (<i>serum tears, next-day</i>)	20%	33%	50%	Max. Possible
OTHER (PLEASE SPECIFY)				
Drug Name/Active Ingredient	Strength		Format/Quantity	
_____	_____		_____	

SIG: _____

Signature

Date

Refills

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