Fax To: 410-666-7253
Email to: rx@hvpcc.com

VITAL DROPS

PATIENT INFORMATION			
Name	DOB	Gender (M/F)	Allergies
Phone			Address
Email			City / State / Zip

PHYSICIAN INFORMATION		
Name		Date
Signature		Address
Email	Phone/Fax	City / State / Zip

PRESCRIPTION INFORMATION

(All Preparations are Preservative Free Unless Otherwise Specified)

DRY EYES			
	Select One or More	*Circle One*	*Quantity (mL) / Supply*
SERUM TEARS	◯ NovoTears	20 % 50%	3-month 6-month supply
	◯ NovoTears Plus with 1% Cyclosporine	20 % 50%	3-month
Medroxyprogesterone Acetate O/S		1%	10 mL 15 mL Other ______
Glycerin O/S		40% 50%	10 mL 15 mL Other ______
Cyclosporine with Artificial Tears O/S		0.5 % 1.0%	10 mL 15 mL Other ______

STAT DROPS (Ready for pick up in two hours after receiving patient authorization; shipped overnight priority to patients unable to pick up)			
	Select One or More	*Circle One*	*Quantity (mL)*
ANTIBIOTICS	◯ Vancomycin O/S	25 mg/mL 50 mg/mL	10 mL 15 mL Other ______
	◯ Tobramycin (Fortified) O/S	15 mg/mL	10 mL 15 mL Other ______
	◯ Ceftazidime O/S	50 mg/mL	10 mL 15 mL Other ______
ANTIFUNGALS	◯ Amphotericin B O/S	1.5 mg/mL	10 mL 15 mL Other ______
	◯ Voriconazole O/S	10 mg/mL	10 mL 15 mL Other ______

Other Medication	Strength	Quantity/Packaging

SIG: ____

Bill to (circle one): Patient Practice