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

OP DROPS™

Hunt Valley PharmaLAB

Practice Name: _____ **Phone Number:** _____

PATIENT INFORMATION			
Name		**Allergies**	
DOB	**Gender (M/F)**	**Address**	
Best Contact Phone #		**City / State / Zip**	
◯ **Patient Pay** ◯ **Practice Pay**		*Deliver to:*	◯ **Physician's Office** ◯ **Patient's Home**

SURGERY INFORMATION			
DATE OF SURGERY #1		◯ LEFT EYE	◯ RIGHT EYE
DATE OF SURGERY #2		◯ LEFT EYE	◯ RIGHT EYE

PRE-OP DROPS	
◯ OpDrop DMK (Dexamethasone 0.1% / Moxifloxacin 0.5% / Ketorolac 0.5%)	◯ One Bottle ◯ Two Bottles
◯ Op Drop PMB (Prednisolone Sodium Phosphate 1% / Moxifloxacin 0.5% / Bromfenac 0.075%	◯ One Bottle ◯ Two Bottles
◯ Op Drop PB (Prednisolone Sodium Phosphate 1% / Bromfenac 0.075%	◯ One Bottle ◯ Two Bottles
◯ Op Drop PM (Prednisolone Sodium Phosphate 1% / Moxifloxacin 0.5%	◯ One Bottle ◯ Two Bottles
DIRECTIONS:	

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

_____ _____

Physician Signature **Date**

P: 410-667-6246
F: 410-666-7253

Hunt Valley PharmaLab
www.HVPCC.com

10 Warren Rd, Suite 220
Cockeysville, MD 21030