

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



Practice Name: _____ Phone Number: _____

PATIENT INFORMATION			
Name		Allergies	
DOB	Gender (M/F)	Address	
Best Contact Phone #		City / State / Zip	
<input type="radio"/> Patient Pay		<input type="radio"/> Practice Pay	
		Deliver to: <input type="radio"/> Physician's Office <input type="radio"/> Patient's Home	

SURGERY INFORMATION			
DATE OF SURGERY #1		<input type="radio"/> LEFT EYE	<input type="radio"/> RIGHT EYE
DATE OF SURGERY #2		<input type="radio"/> LEFT EYE	<input type="radio"/> RIGHT EYE

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

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

Physician Signature

Date

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