



678 WYCKOFF AVE  
 WYCKOFF NJ 07481  
 P 201 891 3334  
 F 201 891 1312

## STERILE VET EYE DROPS ORDER FORM

PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	
PRIMARY PHONE #: <input type="radio"/> CELL <input type="radio"/> HOME <input type="radio"/> WORK	SECONDARY PHONE #: <input type="radio"/> CELL <input type="radio"/> HOME <input type="radio"/> WORK	
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES:

### MEDICATIONS

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acetylcysteine Eye Drops            | <input type="radio"/> 5% <input type="radio"/> 10% <input type="radio"/> 15% | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Chloramphenicol 1% Eye Drops        |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Cidofovir 0.5% Eye Drops            |  | 2ml   |
| <input type="checkbox"/> Cyclosporin                         | <input type="radio"/> 1% <input type="radio"/> 2% Eye Drops                  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Demecarium Bromide                  | <input type="radio"/> 0.125% <input type="radio"/> 0.25%                     | 5ml   |
| <input type="checkbox"/> Diclofenac 0.1% Eye Drops           |  | 5ml   |
| <input type="checkbox"/> EDTA eye drops                      | <input type="radio"/> 1% <input type="radio"/> 2% <input type="radio"/> 3%   | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Fluconazole 0.3% Eye Drops          |  | 5ml   |
| <input type="checkbox"/> Fluconazole 1% / DMSO 10% Eye Drops |  | 5ml   |
| <input type="checkbox"/> Flurbiprofen                        | <input type="radio"/> 0.03% <input type="radio"/> 0.04% Eye Drops            | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Idoxuridine 0.1% Eye Drops          |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Tacrolimus                          | <input type="radio"/> 0.02% <input type="radio"/> 0.03%                      | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Tobramycin ____%                    |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Vitamin A 10000IU/ml                |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Pilocarpine 0.1%                    |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |
| <input type="checkbox"/> Other                               |  | <input type="radio"/> 5ml <input type="radio"/> 10ml <input type="radio"/> 15ml |

Refills:  1  2  3  4  5  6  PRN  NR SIG: \_\_\_\_\_

**WRITE PRESCRIPTION / ADDITIONAL COMMENTS**

DOCTOR	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email
SIGNATURE	DATE (Month / Day / Year)		
	_____/_____/_____		

FAX TO 201-891-1312  
 email to: [orders@yourlifex.com](mailto:orders@yourlifex.com)