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

VITAL DROPS

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

PHYSICIAN INFORMATION				
Name		Date		
Signature		Address		
Email	Phone/Fax Phone:	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	1 Year Refill
SERUM TEARS	◯ NovoTears Plus with 1% Cyclosporine	20 % 50%	3-month 6-month supply	1 Year Refill
◯ 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 _______
ANTIBIOTICS	◯ Tobramycin (Fortified) O/S	15 mg/mL	10 mL 15 mL Other _______
ANTIBIOTICS	◯ Ceftazidime O/S	50 mg/mL	10 mL 15 mL Other _______
ANTIFU-NGALS	◯ Amphotericin B O/S	1.5 mg/mL	10 mL 15 mL Other _______
ANTIFU-NGALS	◯ Voriconazole O/S	10 mg/mL	10 mL 15 mL Other _______

Other Medication	Strength	Quantity/Packaging

SIG: ____