TOWN & COUNTRY
compounding | consultation

Fax to: 201-447-3253
Phone: 201-447-2020

Patient's Name:	Prescriber's Name:
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone #:	Fax #:
PATIENT ALLERGIES:	

PRESCRIBER'S SIGNATURE: X _____ DATE _____

Autologous Serum

❒ Autologous Serum Ophthalmic Drop Solution **(12 X 4 ML) _____% (20% – 100%)**

Other Eye Drop Preparations

❒ Acetylcysteine Ophthalmic Solution **(10 ML) _____5% _____10%**

❒ Albumin Ophthalmic Solution **(4 X 4 ML) _____5%**

❒ Atropine Ophthalmic Solution **(5 ML) _____0.01% _____0.02% _____0.025% _____0.1% _____0.125%**

❒ Amphotericin PF Ophthalmic Solution **(10 ML) _____ 1.5 mg/mL _____ 2 mg/mL**

❒ Cyclosporine MCT Ophthalmic Oil Solution **(10 ML) _____ (0.1% – 1%)**

❒ Cyclosporine (Johns Hopkins) Ophthalmic Solution **1% (10 ML) or (15 ML) _____**

❒ Cyclosporine PF Ophthalmic Aqueous Suspension **1% (10 ML) _____**

❒ Dexamethasone Ophthalmic Solution **(5 ML) _____0.01% _____0.1%**
**Preservative-Free Available (4 ML in 5 Droptainers)* _____

❒ Glycerin Ophthalmic Solution **50% (10 ML) _____**

❒ Mitomycin Ophthalmic Solution **0.02% (1 ML) _____**

❒ Prednisolone PF Ophthalmic Suspension **1% (3 ML) or (5 ML) _____**

❒ Medroxyprogesterone Acetate Ophthalmic Suspension **10 mg/mL (5 ML) _____**

Directions:

❒ **_____ drops OS OU OD _____ times daily** _____

❒ **Other** _____

Refills: (NUMBER OF REFILLS REFERS TO ALL MEDICATIONS PRESCRIBED ABOVE)

❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒1 Year

**PF = Preservative-Free*