TOWN & COUNTRY
compounding | consultation

Anti-Infective Ophthalmic Order Form
ACHC Accredited Pharmacy
Phone: 201-447-2020
Fax: 201-447-3253
Pharmacist@TCcompound.com

Patient's Name:	Prescriber's Name:
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone (CELL):	Fax #:
Email:	Email:
Patient Allergies:	

PRESCRIBER'S SIGNATURE: X_____DATE _____

Anti-Infective Eye Drop Preparations

☐ Amikacin Ophthalmic Solution **(10 ML)_____25mg/mL Other:_____mg/mL**

☐ Cefazolin Ophthalmic Solution **(5 ML) or (10 ML)_____50mg/mL Other:_____mg/mL**

☐ Ceftazidime Ophthalmic Solution **(10 ML)_____50mg/mL Other:_____mg/mL**

☐ Chlorhexidine Digluconate Ophthalmic Solution **(10 ML)_____% (0.02% – 1%)**

☐ Polyhexamethylene Biguanide (PHMB) Ophthalmic Suspension **0.02% (15 ML) _____**

☐ Tobramycin Fortified Ophthalmic Solution **(10 ML)_____mg/mL (13 – 15 mg/mL)**
**Preservative-Free Available (5 ML) _____*

☐ Vancomycin HCl Fortified Ophthalmic Solution **(10 ML)_____mg/mL (14 – 50 mg/mL)**

☐ Voriconazole Ophthalmic Solution **1% (10 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*