TOWN & COUNTRY
compounding | consultation

ACCREDITED Compounding Pharmacy

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 _____

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 W

**PF = Preservative-Free*