COMPOUNDED ATROPINE OPTHALMIC 0.01% DROPS

PATIENT: ________________________________ DOB: ______________ DATE: ________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE: ______________________ ALLERGIES: ______________________ ☐ No Known Allergies

RX

Compounded

Atropine 0.01% Ophthalmic Solution Drops

5 ml (4 -1.25 ml bottles)

☐ Sig: Instill 1 drop OU at bedtime or

as directed____

____

Refills__________

ADDITIONAL NOTES: ____

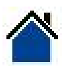
PRESCRIBER SIGNATURE____

PRESCRIBER NAME____

ADDRESS____

CITY/STATE/ZIP____

PHONE____FAX______________________________

 **Customers for Life** **Do the Right Thing** **Make it Safe** **Count on Us**