WEST PLANO DRY EYE & AESTHETICS

AUTOLOGOUS SERUM EYE DROPS:
OPHTHALMIC STERILE COMPOUND RX ORDER

Prescribing Physician:	**NPI:**
Address:	
Phone:	**Fax:**

Patient Name:
Patient DOB:
Patient Phone:

☒ Autologous Blood Serum
Please Check Requested Concentration: ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ Other: _____
Directions (select one): ☐ Apply 1 drop into each eye _____ times daily. ☐ Apply 1 drop into each eye _____ daily x 1 week, then reduce to _____ times daily.
Quantity: As many 5mL bottles as serum will make, not to exceed 12 bottles per order.

Lab Orders: Collection of blood by venipuncture.
Instructions: Based on the concentration of drops prescribed, draw the appropriate number of vials of blood according to West Plano Dry Eye & Aesthetics' autologous serum processing guidelines.
Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Other: _____

Provider Signature: _____ Date: _____