OFFICE NAME: _____

ADDRESS: _____

_____

PHONE: _____

DATE NEEDED: _____

(IF BEING SHIPPED/DELIVERED DIRECTLY TO OFFICE)

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE: _____

DATE OF BIRTH: _____

ALLERGIES: _____

OPHTHALMIC PRODUCT ORDER FORM – DIRECT ADMINISTRATION BY PHYSICIAN

DISPENSE QTY	MEDICATION	DOSAGE FORM	MEDICATION SIG	REFILLS
	Dexamethasone 400mcg/0.1mL Solution	0.2mL (In a TB Syringe)	For Professional Use Only	NR
	EDTA _____ % Solution (Please indicate strength)	5mL Droptainer	For Professional Use Only	NR
	Epinephrine 1:100000/Lidocaine 2% Solution	5mL (In a 10mL Syringe)	For Professional Use Only	NR
	Lidocaine 1%: Phenylephrine 1.5% Solution	1mL Vial	For Professional Use Only	NR
	Phenylephrine 1.5% Solution	1mL (In a 3mL Syringe)	For Professional Use Only	NR
	Tropicamide 1%: Phenylephrine 2.5%:	10mL Droptainer	For Professional Use Only	NR
	Tetracaine 0.5%: Bupivicaine 0.08% Solution	10mL Droptainer	For Professional Use Only	NR
	Riboflavin 0.1% Solution	5mL Droptainer	For Professional Use Only	NR
	Sodium Chloride 5% Ophthalmic Solution	1mL Vial	For Professional Use Only	NR
	Moxifloxacin 0.5% : Ketorolac 0.3% : Prednisolone 1% Pre/Post-Op Cataract Suspension	5mL Droptainer	For Professional Use Only	NR

*MAY ONLY SELECT 1 MEDICATION PER FORM. ADDITIONAL MEDICATIONS MUST BE ORDERED ON A SEPARATE FORM

RC COMPOUNDING SERVICES

3030 Center Rd, Poland, OH 44514

P: 330-707-9001

F: 330-707-9002

info@rccompounding.com

PRESCRIBER INFORMATION DATE: _____

NAME: _____

SIGNATURE: _____

DEA: _____ NPI: _____

FAX FORM TO (330) 707-9002