ATROPINE ORDER FORM

Fax: 866-515-0196

PROMO CODE: MARCOMM2019

Patient: _____ DOB: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ Allergies: _____ ❒ No Known Allergies

Email: _____

☐ **Auto-Refill Program:** By signing here I am requesting to have automatic refills shipped to me monthly.

Parent/Guardian Signature: _____

SELECT ONLY ONE CONCENTRATION BELOW

☐**Atropine 0.01%** ☐**Atropine 0.025%** ☐**Atropine 0.05%**

Ophthalmic Solution Drops
3.5 ml bottle

#Bottles:_____Refills:_____

Directions: Instill 1 drop in OS / OD / OU eye(s) at bedtime.
(Please circle one)

OR:

All orders received will be processed by the following business day for shipping.

Patient is required to call pharmacy for a refill: (855)-466-1076.

All Fields required. Incomplete orders may delay processing.

Patients reserve the right to receive medications from a pharmacy of their choice. I have reviewed my patients medical record and determined the medication(s) ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patients' medical record.

Prescriber Signature: _____ Prescriber Name: _____

Facility Name: _____ Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Prescriber Email: _____

Shipping: ❒ Ship to Office ❒ Ship to Patient **Payment:** ❒ Doctor ❒ Patient ❒ Pharmacy call patient for payment

Credit Card Number: _____ Exp: _____ CVC: _____

Credit Card on file ending in: _____