# Lihue Pharmacy

## Atropine Eye Drop Order Form

Fax to (808) 246-9199 or
Email to prescriptions@kauairx.com

Date: _____

Patient: _____ DOB: ____/____/_____

Address: _____

Parent/Guardian: _____ Phone: _____

Patient's Allergies: _____ ☐ No Known Allergies

☐ Atropine 0.01% ☐ Atropine 0.02% ☐ Atropine 0.03%

☐ Atropine 0.04% ☐ Atropine 0.05%

**Opthalmic Solution**

Directions: Instill one drop

☐ OS ☐ OD ☐ OU

at bedtime.

Quantity: 5 ml Bottle

Refills: ____

☐ Auto Refill for Patient and Bill Doctor's Office

Prescriber Name: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Prescriber's Signature: _____