LIHUE PHARMACY INC.

4491-A Kolopā St.

Lihue Hi. 96766

Phone: 808-246-9100 Fax: 808-246-9199

EMAIL: prescriptions@kauairx.com

ATROPINE EYE DROPS PRESCRIPTION FORM

Patient Name:	
Date of Birth:	
Ship to Address:	
If minor, parent Information: FIRST AND LAST NAME	
Phone #	

Check ☑ Box Below:

Atropine Opth. Drops: 15ml	☐ 0.01%	☐ 0.02%	☐ 0.03%	☐ 0.05%	☐ 0.10%
Directions:	Instill 1 drop into: ☐ Left Eye ☐ Right Eye ☐ Both Eyes **AT BEDTIME.**				
Alternate Directions:					
Refills: _____	**Diagnosis Code:**				

Physician's Certificate: I ☐ certify / ☐ recertify that this patient is under my care and that the above-described Products/Services are medically necessary.

Physician's Signature:	**Date:**
Physician Print Name:	**Address:**
Phone #:	**Fax#:**
NPI:	**DEA:**

****PLEASE FAX ORDERS TO: (808) 246-9199****