



LIHUE PHARMACY INC.

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ATROPINE EYE DROPS PRESCRIPTION FORM

PATIENT INFORMATION		
Patient Name (Print First & Last Name)		
Birthdate	Phone #	
Ship to Address		
City	State	Zip

Check Strength Box Below:

Atropine Opth. Drops: 15ml	<input type="checkbox"/> 0.01%	<input type="checkbox"/> 0.02%	<input type="checkbox"/> 0.025%	<input type="checkbox"/> 0.05%	<input type="checkbox"/> 0.10%
Directions:	Instill 1 drop into: <input type="checkbox"/> Left Eye <input type="checkbox"/> Right Eye <input type="checkbox"/> 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 EMAIL / FAX ORDERS TO: (808) 246-9199****