

**PHYSICIAN'S ORDER FORM**

LABEL SHEET BEFORE PLACING IN CHART. DATE, TIME AND PHYSICIAN'S SIGNATURE MUST APPEAR FOR EACH SET OF ORDERS. USE APPROVED ABBREVIATIONS ONLY. EACH TIME NEW ORDERS ARE WRITTEN SEND TO PHARMACY. DISCONTINUE ORDERS IN WRITING. COUNTER SIGN TELEPHONE ORDERS. PATIENT WEIGHT AND HEIGHT PERTAINS TO THAT ON ADMISSION. THE GENERIC, THERAPEUTIC OR PHARMACOLOGIC EQUIVALENT WILL BE DISPENSED UNDER THE FORMULARY SYSTEM, UNLESS THE PHYSICIAN SPECIFIES, "DISPENSE AS WRITTEN."

PATIENT ALLERGIC TO		NONE	ASPIRIN	SULFA	PENICILLIN	OTHER	PT. WGT.	PT. HGT.
ORDERED		<b>Laser Room Order</b> (Check appropriate boxes and fill in blank.)						
DATE	TIME	<b>DO NOT USE ABBREVIATIONS</b> U, IU, Q.D., QD, q.d., qd, Q.O.D, QOD, q.o.d., qod, trailing zero (X.0 mg), lack of leading zero (.X mg), MSO <sub>4</sub> , MgSO <sub>4</sub> , MS						
		Diagnosis:					<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left Eye
<b>To be administered by Physician in Procedure Room</b>								
		<input type="checkbox"/> Brimonidine (Alphagan P) 0.15% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Cyclopentolate (Cyclogyl) 1% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Dacriose (or equivalent Opth Irrigation Soln)	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Flourometholone (FML) Suspension	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Homatropine 5% Opth Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Hydromellose Opth Demulcent 2.5% (GONAK)	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Phenylephrine (Neosynephrine) 2.5% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Phenylephrine (Neosynephrine) 10% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Pilocarpine 1% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Pilocarpine 2% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Pilocarpine 4% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Proparacaine (Alcaine) 0.5% Soln (Refrigerator)	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Predniolone (Pred-Forte) 1% Suspension	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Timolol (Timoptic) 0.25% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Timolol (Timoptic) 0.5% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Tropicamide (Mydracyl) 1% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Tropicamide (Mydracyl) 0.5% Solution	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Apraclonidine (Iopidine Duopack)	Instill _____ drops in			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Polymixin B-Bacitracin (Polysporin) Opth Ointment	Apply to			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		<input type="checkbox"/> Fluorescein Sodium Strips	1 Strip			<input type="checkbox"/> Right	or	<input type="checkbox"/> Left eye
		Physician Signature:			Date:		Time:	