Patient Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____
Zip: _____

Phone:_____

Tobramycin 15 mg/ml

Sig. ☐ 1 gtt ☐ Q2 hrs ☐ Other _____

☐ OS ☐ OD ☐ OU

Vancomycin 25 mg/ml

Sig. ☐ 1 gtt ☐ Q2 hrs ☐ Other _____

☐ OS ☐ OD ☐ OU

Sig:

Notes:

Signature: _____
Prescriber: _____ Phone: _____
Clinic: _____ DEA: _____
Address: _____

Please **print**, **sign** and **fax** form to 970-663-7478 Clear Form