Patient Name: _____ DOB: _____ Date: _____

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

Phone:_____

Atropine

☐ 0.01 % ☐ 0.02% ☐ 0.025% ☐ 0.03% ☐ 0.05%
☐ other _____

☐ OS ☐ OD ☐ OU

Sig:

Notes:

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

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