AUTOLOGOUS SERUM EYE DROPS PRESCRIPTION REQUEST FORM

PROVIDER INFORMATION

Prescriber Name: _____ NPI/DEA: _____

Key Contact: _____ Phone: _____

Address: _____ Fax: _____

City, State, Zip: _____ Email: _____

PATIENT INFORMATION

☐ New Patient ☐ Continued Care

Patient Name: _____

Address: _____

City, State, Zip: _____ Date of Birth: _____ Sex: _____

Preferred Phone: _____ Known Allergies: _____

Alternate Phone: _____ _____

Email: _____ Diagnosis: _____

ORDER INFORMATION

☐ Standard Medication: Serum Autologous 20% GTTS Dosage Directions: _____

☐ Other concentration: _____ _____

Supply: ☐ 1-month ☐ 3-month Additional Instructions: _____

Refills: _____ _____

Prescriber Signature: _____ Date: _____

Please send this form to SDEB via:
Email: ased@sdeb.org or **Fax: (858) 694-0116**
If you have questions or concerns, please contact us.
Tel: (858) 694-0400 x 6001

SDEB Use Only
Order Number: _____
Order processed by: _____
Date & Time: _____
Notes: _____

San Diego Eye Bank
3870 Murphy Canyon Rd. Unit 250
San Diego, CA 92123
Phone: 858.694.0400
Fax: 858.694.0116

San Diego Eye Bank
ASED-OF1
Established: 10/19 RN
Revised: 3/21:RN