RETINA – VITREOUS ASSOCIATES OF FLORIDA

Diabetic Retinopathy • Macular Degeneration • Macular Hole Macular Pucker • Uveitis
Retinal Vascular Occlusion • Retinal Detachment • Pediatric Retina • Ocular Tumors

Scott E. Pautler MD
Steven M. Cohen MD
Karina Billiris Findlay MD
David A. Eichenbaum MD

DATE: _____

PATIENT'S NAME: _____ **DOB:** _____

PHARMACY AND PRESCRIPTIONS

In order to better serve you, our patient's, we are utilizing an Electronic Prescription program to send your prescriptions directly to your pharmacy. In order to more efficiently process your prescriptions, please provide us with your primary pharmacy's information.

If you utilize a mail order pharmacy for long-term medications, please provide us with both your mail order pharmacy information and a local pharmacy you use as well. If your pharmacy participates, we will electronically send your prescription directly to them. If they do not participate, we will continue to call in your prescriptions for you.

Some medications can only be accepted by the pharmacy as a written prescription signed by your physician. If that is the case, we will still give you a signed prescription that you will need to take to your pharmacy.

PRIMARY PHARMACY

Pharmacy Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: (_____) _____ - _____ ☐ **Mail Order (3-month)** ☐ **Local Pharmacy** ☐ **Both**

SECONDARY PHARMACY

Pharmacy Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: (_____) _____ - _____ ☐ **Mail Order (3-month)** ☐ **Local Pharmacy** ☐ **Both**

NOTES

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