**Endophthalmitis Intravitreal Drug Request Form**

**To be taken to the INPATIENT Pharmacy**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patients Details | | Patients Consultant | | Date | |
|  | |  | |  | |
| Name: | | | | | |
| Address: | | | | | |
| Hospital number: | | | | | |
| D.O.B.: | | | Intravitreal Kits required | | 🗸 |
|  | | | **Vancomycin 2mg/0.1ml** | |  |
| **Amikacin 0.4mg/0.1ml** | |  |
|  | Sign | | Print | | Date |
| Issued from EDC by |  | |  | |  |
| Received by |  | |  | |  |
| Kits booked out by |  | |  | |  |
| Kits replaced in EDC by |  | |  | |  |

Requesting Doctor’s Signature: Date:

Requesting Doctor’s Name (printed):

Form to be retained in Pharmacy.