**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.