(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use DD Form 2005.)

EYEWEAR PRESCRIPTION	DATE	ACCOUNT NUMBER	ORDER NUMBER

TO: *(Lab)*	FROM:
NOSTRA	

NAME *(Last, First)*	SSN Last 4 only	GRADE

ADDRESS/UNIT	PHONE
ADDRESS CONTINUED	SHIP TO: ☐ CLINIC ☑ PATIENT
CITY, STATE, ZIP	

AD	RES	NG	RET	OTHER*	A	N	AF	MC	CG	PHS	OTHER*

FRAME	EYE	BRIDGE	TEMPLE	COLOR
AF-JS		22	130 STB	Black

PD DIST / NEAR	LENS	TINT	MATERIAL	PAIR	CASE

	SPHERE	CYLINDER	AXIS	DECENTER	H PRISM	H BASE	V PRISM	V BASE
R								
L								

MULTIVISION				LAB USE
	NEAR ADD	SEG HT	TOTAL DECENTER	
R				
L				PRIORITY / TECH INITIALS

SPECIAL COMMENTS/JUSTIFICATION *(*Use this space to specify blocks marked "Other.")*

PRESCRIBING OFFICER/AUTHORITY	SIGNATURE

DISTRIBUTION: **ORIGINAL** - Retained by Lab. **COPY 1 -** Returned with eyewear. **COPY 2** - Entered in health record.

DD FORM 771, JUL 96 PREVIOUS EDITION IS OBSOLETE.

Highlighted fields are mandatory

Clear Form

Email Form