

EYEWEAR PRESCRIPTION

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

ORDER NUMBER		ACCOUNT NUMBER		DATE (YYYYMMDD)	
TO: (Lab)			FROM:		
NAME (Last, First, Middle Initial)			SSN		GRADE
ADDRESS/UNIT (Street, City, State, Zip Code)				PHONE (Include area code)	
				SHIP TO: (X all that apply) ☐ CLINIC ☐ PATIENT	
AD	RES	NG	RET	OTHER*	
☐	☐	☐	☐	☐	
A	N	AF	MC	CG	PHS
☐	☐	☐	☐	☐	☐
FRAME		EYE		BRIDGE	TEMPLE
DIST		NEAR	LENS		TINT
PD /					
	SPHERE	CYLINDER	AXIS	DECENTER	H PRISM
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.