

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) <input type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT					
AD	RES	NG	RET	OTHER*	A	N	AF	MC	CG	PHS	OTHER*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FRAME			EYE		BRIDGE		TEMPLE		COLOR			
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.