EYEWEAR PRESCRIPTION

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

ORDER NUMBER	ACCOUNT NUMBER	DATE *(YYYYMMDD)*

TO: *(Lab)*
NMRLC-NORA
160 MAIN RD STE 350
YORKTOWN, VA, 23691
TEL: (757)887-7600 EXT: 1
usn.nora.customerservice@health.mil

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	OTHER*
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

FRAME	EYE	BRIDGE	TEMPLE	COLOR
Walter	Select Eye Size	17	Select Temple	Select Color

DIST / NEAR	LENS	TINT	MATERIAL	PAIR	CASE
PD /	Select Lens	Select Tint			

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

MULTIVISION

	NEAR ADD	SEG HT	TOTAL DECENTER
R			
L			

LAB USE

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.