

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.											