

EYEWEAR PRESCRIPTION

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

ORDER NUMBER	ACCOUNT NUMBER	DATE (YYYYMMDD)
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TO: (Lab)	FROM:
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NAME (Last, First, Middle Initial)	SSN	GRADE
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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
DIST NEAR	LENS	TINT	MATERIAL	PAIR CASE
PD /				

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