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	OTHER*
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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