



CUSTOM LENS ORDER SPECIFICATION FORM

Account Name _____

Account # _____ Phone _____

Contact Person _____ Order Date _____

Patient Name _____
Last First Ship completed lens order to:
 Office Patient

Patient Street Address _____ Apt or Suite# _____

City _____ State _____ Zip _____ Patient Phone # _____

Shipping Method 1st Class Mail Ground (minimum for Soft CL's & mail-to-patient orders) 2-day Overnight

ORDER TYPE

- New GP Lens W NW — **OR** — GP Lens Exchange - Invoice # _____
- New Soft Lens W NW — **OR** — Soft Lens Exchange - Invoice # _____
- Soft Lens NW 2 Lens Value Pack - Original Invoice # _____

GP Material _____ Design _____ Tint _____ w/Plasma Treatment

Soft Lens Material Acofilcon B 49% Hioxifilcon B 49% **Visi-tint** Blue Clear

Soft Lens Design **Intelliwave®** Asphere Aspheric Toric Multifocal Multifocal Toric

	Keratometer Readings	Spectacle Rx	Add Power	HVID	Pupil	Dominant
OD						
OS						

	Base Curve	Diameter	Power	Add Power	Dominant
OD					
OS					

ADDITIONAL SPECIFICATIONS - GP LENS ORDERS ONLY

	Peripheral Curves	Prism	Seg Height	Truncation
OD	<input type="checkbox"/> ID Dot <input type="checkbox"/> Drill Dot			
OS				

ADDITIONAL SPECIFICATIONS - INTELLIWAVE SOFT LENS ORDERS ONLY

	Over Refraction	Rotation
OD		
OS		

NOTES _____

CONSULTATION ASSISTANCE: 800.566.8001

ORDER BY PHONE: 800.253.9364

ORDER BY FAX: 800.648.2272