



CUSTOM LENS ORDER SPECIFICATION FORM

Account Name _____

Account # _____ Phone _____

Contact Person _____ Order Date _____

Patient Name _____ Patient Date of Birth _____
Last First

Patient Street Address _____ Apt or Suite# _____

Ship completed lens order to:
 Office Patient

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 Replacement - # of lenses OD _____ OS _____ Invoice # _____

GP Material _____ Design _____ Tint _____ w/Plasma Treatment w/THP

Soft Lens Material: (6 mo. replacement) Hioxifilcon B 49% Acofilcon B 49% Blue Visi-tint Clear

(quarterly replacement) Definitive Silicone Hydrogel 74% Blue Visi-tint Clear

	Keratometer Readings	Spectacle Rx	Add Power	HVID	Pupil	Dominant
OD						
OS						

	Base Curve	Diameter	Power	Add Power	CT	OZ	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 _____

NEW INVOICE NUMBER _____

CONSULTATION ASSISTANCE: 800.566.8001

ORDER BY PHONE: 800.253.9364

ORDER BY FAX: 800.648.2272