



# 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  NW  NoRiskW  GFP — **OR** —  GP Lens Exchange - Invoice # \_\_\_\_\_

New Soft Lens  NW  NoRiskW  GFP — **OR** —  GP 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 \_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_

NEW INVOICE NUMBER \_\_\_\_\_

CONSULTATION ASSISTANCE: 800.566.8001

ORDER BY PHONE: 800.253.9364

ORDER BY FAX: 800.648.2272