

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

EYEWEAR PRESCRIPTION				DATE	ACCOUNT NUMBER	ORDER NUMBER					
TO: (Lab)				FROM:							
NAME (Last, First)			SSN	GRADE							
ADDRESS/UNIT				PHONE							
ADDRESS CONTINUED				SHIP TO: <input type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT							
CITY, STATE, ZIP											
AD	RES	NG	RET	OTHER*	A	N	AF	MC	CG	PHS	OTHER*
FRAME		EYE		BRIDGE		TEMPLE		COLOR			
PD	DIST	NEAR	LENS		TINT		MATERIAL		PAIR	CASE	
	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.