(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:** ☐ CLINIC ☐ 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			
	NEAR ADD	SEG HT	TOTAL DECENTER
R			
L			

LAB USE	
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.