

COMPANY NAME City, State, Zip Code Phone Number, Email			DR. NAME DR. NAME		
Name:			Rx Date:		
SPECTACLE Rx:			Expires: <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years		
	Sph	Cyl	Axis	Prism	Add
OD		-	x		
OS		-	x		
Comments/Recommendations:			<input type="checkbox"/> Anti-reflection + Anti-Scratch <input type="checkbox"/> High Index <input type="checkbox"/> Polarized <input type="checkbox"/> Polycarb		
CONTACT LENS Rx:			Expires: 1 year from RX date		
	BC	DIA	POWER	TYPE	AKA/OTHER
OD					
OS					
Replace lenses every: Comments/Recommendations:			No Substitution Without Doctor Approval _____, OD		