FORM B

CONTACT LENSES
CUSTOM ORDER CERTIFICATION

This form must be complete or your order will be delayed until we can contact you.

Date:____________________

Practitioner Name:____

Practitioner Address (rubber stamp ok):______________________________

____

Telephone:____________________ Fax:______________________

Patient's Name:____

Color Desired:________ IRLEN TINTS ____________________________

Contact Lens Mfg. & Type:_____________________________________
(From Approved List)

Rx: O.D.________________________ B.C.______________

O.S.________________________ Diam.______________

Rx Expiration Date::_______________________________

Remarks:____

____

I certify that I am a licensed practitioner and request that you alter the enclosed lenses (devices) in accordance with my directions above. These lenses are to be used solely in my practice.

Dr. Signature **Required**:______________________________________

Irlen Institute
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