

Prescription Order Form

Company Name: _____

Telephone number: _____

Company Purchase Order #: _____

Patient's Name: _____ Date: _____

Ship To Address: _____

City: _____ State: _____ Zip: _____

Glasses Model #: _____

Lead Equivalency:

.50mm .75mm

Distant:

	Sph.	Cyl.	Axis	Dec.	Prism	Base
R						
L						

Add for read:

	Segment Height	Segment Widt	Segment Dec.	Total Dec.
R				
L				
	PD -	Distant	Near	

IMPORTANT: For proper prescription centering PD MUST BE INCLUDED.
 In order to process prescription orders, we require the dispensing opticians signature!

Dispensing Opticians Signature _____

Please photo copy this form and mail or fax to:

Infab Corporation
 3651 Via Pescador
 Camarillo, CA 93012
 Tel: (805) 987-5255 Fax: (805) 482-8424

