

PRESCRIPTION ORDER FORM

ORDER Via FAX: 1-877-302-6385
 Email: ivc1@visualcompassion.com
 OR ONLINE: www.infocusonline.org



VISUAL COMPASSION

DATE: _____ PHONE: _____

PATIENT NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

ORGANIZATION: WEB ORDER

PROMO CODE: InFOCUS

DOCTORS NAME: _____

EXAM DATE: _____

Check one:

- Mail to Vision Station
- Mail to Patient (add \$5)
- In-House Job

FRAME: <input type="checkbox"/> Metal <input type="checkbox"/> Zyl <input type="checkbox"/> Semi-rimless <input type="checkbox"/> POF w/ waiver <input type="checkbox"/> Level _____	FRAME MODEL #: _____
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FRAME SIZE: A: B: DBL: ED:	FRAME COLOR: _____
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Rx	SPH	CYL	AXIS	ADD	PRISM	
					Diopter	Base
R						
L						

OC HT (center of pupil)	SEG HT (Must be ≥10mm)	PUPILLARY DISTANCE			
		DVPD OU	OD DVPD	NVPD OU	OD NVPD
			OS DVPD		OS NVPD

OFFICE USE ONLY: ORIGINAL ORDER THIS IS A REORDER

Lenses Ordered: date: _____ Initial: _____ Lab _____

Date Shipped _____ Lenses Arrived _____

Order Completed _____ Rx Verified _____

DPL: _____

LENS MATERIAL					
FULL FRAME		SEMI-RIMLESS		TINT	
\$0	\$10	\$35	\$10	\$35	\$10
CR-39	Poly	HI	Poly	HI	solid
					grey brown

LENS DESIGN		OVERAGE CHARGES	
SINGLE VISION (Requires OC HT)	BIFOCAL (Requires SEG HT)	Any SPH (>+4 ≤+6) or (>-6 ≤-8) and/or Any CYL (>-2 ≤-4) (Add \$10)	
		Any SPH (>+6) or (>-8) and/or Any CYL (>-4) (Add \$20)	
\$10	\$10	\$25	Any Bifocal ADD > +3.00 (Add \$10) Oversized frame: A>59 B>45 (Add \$10)
Distance	Reading		

Special Instructions/Requests: _____

Tint is only for:
 SV: CR-39 or poly (NO HI) AND
 BI: CR-39 or HI (NO POLY)

DESCRIPTION	COST
Lens Design (\$10 or \$25)	
Material (\$0 or \$10)	
Overage (\$10 or \$20) x/x	
Tint (\$10)	
Frame style cost by code	
Ship to Patient (\$0 or \$5)	
Total Due	