Z&Z Medical, Inc
Your Source for Medical Imaging Supplies

PRESCRIPTION FORM

CUSTOMER NAME: ______________________________

ORDER NUMBER: ______________________________

PLEASE FAX FORM TO: 319-277-3998 or email to orders@zzmedical.com

Check box indicating prescription type (one of three) below

SINGLE VISION PRESCRIPTION **YES** ☐

	SPHERE	CYLINDER	AXIS	PRISM	BASE ▲▼	PUPILARY DISTANCE
OD (RIGHT EYE)						
OS (LEFT EYE)						

INFORMATION NEEDED:
1) DISTANCE Rx ONLY
2) PUPILARY DISTANCE
3) VERIFY Rx IS CURRENT FOR THE YEAR

BIFOCAL PRESCRIPTION **YES** ☐

PROGRESSIVE PRESCRIPTION **YES** ☐

	SPHERE	CYLINDER	AXIS	PRISM	BASE ▲▼	PUPILARY DISTANCE
OD (RIGHT EYE)						
OS (LEFT EYE)						
ADD						

INFORMATION NEEDED:
1) DISTANCE Rx
2) ADD BIFOCAL POWER
3) PUPILARY DISTANCE
4) VERIFY Rx IS CURRENT FOR THE YEAR

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