# 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 □

<table>
<thead>
<tr>
<th>SPHERE</th>
<th>CYLINDER</th>
<th>AXIS</th>
<th>PRISM</th>
<th>BASE ▲▼</th>
<th>PUPILARY DISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD (RIGHT EYE)</td>
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<tr>
<td>OS (LEFT EYE)</td>
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</tbody>
</table>

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

## BIFOCAL PRESCRIPTION YES □

## PROGRESSIVE PRESCRIPTION YES □

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

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