Order Form

TO ORDER: 866-404-1060 / orders@specialeyesqc.com **TO CONSULT:** 866-822-2020 / consult@specialeyesqc.com

Date: Account Name:

Ordered By: Account Number:

Patient Name (Last, First)

	OD	OS	Multifocal/Bifocal	OD	OS
K readings			**ADD POWER**		
Spectacle Rx			**Pupil Size** Ambient or Bright		
HVID			**Eye Dominance** Dominant or Non-dominant		

Please Select

Lens Type	**49 Toric/Sphere** ☐	**54 Toric/Sphere** ☐	**59 Toric/Sphere** ☐	**54 Multifocal** ☐	**54 Bifocal** ☐
Order type	**Trial 1st** ☐	**Trial 2nd** ☐	**Supply** ☐	**Other** ☐ (Please indicate reason)	

Lens Ordered

	Base Curve	Diameter	Sphere	Cylinder	Axis	# of lenses	Multifocal/Bifocal N/C or D/C	Center Zone Size	Multifocal only Perpheral Zone Size
OD									
OS									

Delivery

Standard 4-Day ☐	**Drop Ship To:**	Name:
Expedite 2-Day ☐	☐ Patient	Address:
Saturday Delivery ☐	☐ Other	City/State: Zip

Comments

specialeyes for precision vision