

CONTACT LENSES CUSTOM ORDER CERTIFICATION

This form must be complete or your order will be delayed
until we can contact you.

Date: _____

Practitioner Name: _____

Practitioner Address (rubber stamp ok): _____

Telephone: _____ Fax: _____

Patient's Name: _____

Color Desired: IRLEN TINTS

Contact Lens Mfg. & Type: _____
(From Approved List)

Rx: O.D. _____ B.C. _____

O.S. _____ Diam. _____

Rx Expiration Date: _____

Remarks: _____

I certify that I am a licensed practitioner and request that you alter the enclosed lenses (devices) in accordance with my directions above. These lenses are to be used solely in my practice.

Dr. Signature Required: _____

Irlen Institute
5380 Village Road, Long Beach, CA, 90808
Tel: 562-496-2550 Fax: 562-429-8699