CR Studios Custom Device Order

This form must be completed to be able to process your order.

Contact Name; _____ *Phone;*_____ *Date;*_____

Account billing

*Name;*_____

Email; _____

*Address;*_____

*Patient's Name;*_____

*Color desired;*_____

*Brand of Lens;*_____

Specifications of lenses (RX)

<u>Please be advised that all sizes are final. Please include pupil and iris size</u>

(Standard sizes 11.5 iris 4.5 clear or black centers)

*O.D. Base Curve;*_____ *Power;*_____ *Diameter;*_____

*O.S. Base Curve;*_____ *Power;*_____ *Diameter;*_____

Solid Color _____ *Clear Center*_____ *Black Pupil* _____

*Previous Patient*_____ *New Patient*_____

*Notes;*_____

I CERTIFY THAT I AM A LICENSED PRACTITIONER AND REQUEST THAT YOU ALTER THE ENCLOSED LENSES (DEVICES) IN ACCORDANCE WITH MY DIRECTIONS. THESE LENSES ARE TO BE USED SOLEY IN MY PRACTICE.

*SIGNATURE;*_____ *DATE;*_____

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