

Fax Toll Free to 1-800-401-1495

P. O. Box 366 Louisiana, MO 63353 Phone: 1-800-570-5367 Fax: 1-800-401-1495

Instructions: If you would like to order by fax or mail you can print this form and fill it out. Please make sure that all of your entries are complete and clearly legible to ensure quick processing. Orders within the US can be faxed to 1-800-401-1495 (International 001-573-754-3600) or mailed to Contacts America, P. O. Box 366, Louisiana, MO 63353.

Prescription Information							
Left	Eye (OS)				F	Right Eye	(OD)
			LENS N/	AME:			
			BASE CURVE	(BC):			
			DIAMETER (DIA):			
			POWER (Sph	ere):			
		CY	LINDER (for To	oric):			
			AXIS (for To	oric):			
			ADD (for Bife	ocal):			
			COLOR (Optic	onal):			
			QUAN	TITY:			
Eye Care Practitioner							
		Do	ctor / Store Ph	none:			
			Patient Birtho	date:			
mation							
		State			Zip / Postal Code:		
			L		<u> </u>		
		E	Evening Phone:				
○ Expedited	○ 2nd Day	(Next Day		C Internatio	onal	(SELECT ONE)
tion							
⊖ Visa	O Master Card) k	Discover		○ American	Express	(SELECT ONE)
				Exp	piration Date:		
		State	:		Zip / Post	al Code:	
	Left Left	Left Eye (OS)	Left Eye (OS)	Left Eye (OS) LENS N/ BASE CURVE DIAMETER (DIAMETER (POWER (Sphinger) CYLINDER (for Trest) AXIS (for Trest) AXIS (for Trest) ADD (for Bifder) COLOR (Optice) QUAN tioner Doctor / Store Phinger) Doctor / Store Phinger) Patient Birther State: Evening Phone Expedited 2nd Day Next Day tion Evening Phone Evening Phone	Left Eye (OS) LENS NAME: BASE CURVE (BC): DIAMETER (DIA): DIAMETER (DIA): POWER (Sphere): CYLINDER (for Toric): AXIS (for Toric): AXIS (for Toric): ADD (for Bifocal): COLOR (Optional): COLOR (Optional): UANTITY: VISION Toricon Patient Birthdate: Patient Birthdate: Patient Birthdate: State: State: Circon State: Circon State: Master Card Discover Expedited 2nd Day Visa Master Card Discover Expedited Expedited Expedited	Left Eye (OS) ILENS NAME: ILENS NAME: BASE CURVE (BC): BASE CURVE (BC): DIAMETER (DIA): POWER (Sphere): CYLINDER (for Toric): AXIS (for Toric): AXIS (for Toric): ADD (for Bifocal): COLOR (Optional): COLOR (Optional): COLOR (Optional): Doctor / Store Phone: Patient Birthdate: mation Patient Birthdate: State: Zip / Post Evening Phone: Zip / Post Cion Master Card Discover Visa Master Card Discover American Expiration Date: Expiration Date: Expiration Date:	Left Eye (OS) Right Eye LENS NAME: