



shamir

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ABN 67 006 180 776

Practice name: _____ Account No. _____ Date: ___ / ___ / ___

Patient name: _____ Date Required: ___ / ___ / ___

LENS TYPE

	Sph	Cy	Axis	Addition	Prism 1	Prism 2
Right	_____	_____	x _____	_____	_____	_____
Left	_____	_____	x _____	_____	_____	_____

	Dist PD	Near PD	Height	OC Height	FFA	_____
Right	_____	_____	_____	_____	PANTO	_____
Left	_____	_____	_____	_____	BVD	_____

Uncut Fitted Frame enclosed Frame to follow

FRAME DETAILS

Width _____ Depth _____ Widest _____ Bridge _____ Type _____

Manufacturer _____ Name _____

Special Instructions

Frame Shape