

**SAMPLE  
PRESCRIPTION FOR  
POST CATARACT GLASSES**

ANYTOWN OPTICAL, USA

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HIC# \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_ DX: \_\_\_\_\_ OD OS

R <sub>x</sub>		SPHERE	CYLINDER	AXIS	PRISM	BASE
D.V.	O.D.					
	O.S.					
N.V.	O.D.					
	O.S.					

U.V. COATING       Bifocal       Trifocal

OVERSIZE LENS FOR \_\_\_\_\_

ANTI-REFLECTIVE COATING FOR: \_\_\_\_\_

SPECIAL TINT FOR: \_\_\_\_\_

OTHER SPECIAL FEATURE: \_\_\_\_\_

PATIENT REQUEST:                       PROGRESSIVE LENS  
                                                  SCRATCH RESISTANT COATING

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ OD/MD