ultravision CLPL

KERASOFT® IC

KeraSoft® IC Full Periphery Order Form

Account Number: _____ Patient Reference: _____

Lens Material: SiH / 77% *

Right Lens	BCOR (mm)	Diameter (mm)	Periphery	Power	Cyl	Axis	BVD
Prescription of Trial/ Previous Lens *							
Over Refraction							
Laser Mark	Compensated for in order: Yes / No *			**Rotation:	°	Clockwise / Anti-clockwise *	

Left Lens	BCOR (mm)	Diameter (mm)	Periphery	Power	Cyl	Axis	BVD
Prescription of Trial/ Previous Lens *							
Over Refraction							
Laser Mark	Compensated for in order: Yes / No *			**Rotation:	°	Clockwise / Anti-clockwise *	

* Delete as applicable.
** If rotation is greater than 20º please recheck the fit.

Office Use Only:

Final Prescription of Ordered Lens Order No:

	BCOR (mm)	Diameter (mm)	Periphery	Power	Cyl	Axis
Right Lens						
Left Lens						

THE QUEEN'S AWARDS FOR ENTERPRISE: INNOVATION 2010

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