



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 20° 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						



Record No. 265 – Issue 3 – 14.12.09

