

FORM B

**CONTACT LENSES  
CUSTOM ORDER CERTIFICATION**

This form must be complete or your order will be delayed  
until we can contact you.

Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_

Practitioner Address (rubber stamp ok): \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Color Desired: IRLEN TINTS

Contact Lens Mfg. & Type: \_\_\_\_\_  
(From Approved List)

Rx: O.D. \_\_\_\_\_ B.C. \_\_\_\_\_

O.S. \_\_\_\_\_ Diam. \_\_\_\_\_

Rx Expiration Date: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

I certify that I am a licensed practitioner and request that you alter the  
enclosed lenses (devices) in accordance with my directions above. These  
lenses are to be used solely in my practice.

Dr. Signature Required: \_\_\_\_\_

Irlen Institute  
5380 Village Road, Long Beach, CA, 90808  
Tel: 562-496-2550 Fax: 562-429-8699