AMINU KANO TEACHING HOSPITAL, KANO.

OPTICAL PRESCRIPTION FORM

UNIT NO _____ DATE _____

Surname _____ First Name _____

Address _____

_____

R_x	RE (VA)				LE (VA)			
	Sph	Cyel	Axis	Prism	Sph	Cyel	Axis	Prism
Constant								
Near / Add								

Patients P. D: _____ Bridge: _____

Frame Eye Size/P.D _____ Temple: _____

Decentration: _____

Segment Measurement _____

FRAME TYPE COLOR _____ COST (N) _____

LENS TYPE COLOR _____ COST (N) _____

OTHER SPECIFY e.g. GLAZING ONLY _____ _____

SURFACING _____

CASE (Size) _____

TOTAL COST N: **K**

DATE OF COLLECTION

_____

Consultant Ophthalmologist