Mission Eye Clinic

Spectacle Rx Re-Check

If you have troubles seeing or adapting your new glasses. Please ask the original optical to complete this form so we can better understand the problems and help solve the issues.

Date: _____ Patient's Name: _____

Optician/Optical: _____

Please fill out the form below carefully and completely.

To be verified	Old spectacles	New spectacles
Rx		
PD		
Lens type, brand name, PAL design		
Seg height		
Lens material, index		
Lens treatments, coatings		
Base curve		
Pantoscopic tilt		
Prisms		

Patient's distance PD _____ near PD _____ Date purchased:_____

Optician's observations/actions: _____

_____

_____