



IOL PURCHASE REQUISITION

MEDICARE PATIENTS ONLY

DEPARTMENT: _____ DATE NEEDED: _____ DATE REQUESTED: _____ DELIVERY

QTY.	DESCRIPTION LENS INFORMATION	UNIT PR.	P.O.#	DATE P.O.	VENDOR	DATE
	<u>Company</u>					
	PATIENT NAME:					
	PATIENT MEDICARE #:					
	DATE OF SURGERY:					
	PHYSICIAN:					
	RECEIVED ON: _____					
	By: _____					
	PLEASE NOTE: 1 FORM PER PATIENT					
	LENSES WILL NOT BE ORDERED					
	WITHOUT A MEDICARE NUMBER					

LATEX ALLERGY: NO YES

Please FAX to Colleen Malizia, RN, Ophthalmology Clinician: (631) 351-2696
 Telephone: 760-2122 Beeper: 340-0775

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