

Boots Opticians contact lens specification form

This form must be completed and signed by your Optician

Patient Name Title ___ Firstname _____ Surname _____

Patient Date of Birth ____/____/____

Patient Telephone Number _____

Contact Lens Type and specification

	Contact Lens Manufacturer	Contact Lens Type	Contact Lens Specification					
			BC	DIA	SPH	CYL	AXIS	ADD
Right								
Left								

Specification Expiry Date ____/____/____

Your Optician's Details

Optometrist/Contact Lens Practitioner Title ___ Firstname _____ Surname _____

GOC Number ____ - _____

Practice Name _____

Practice Address _____

Postcode _____

Practice Telephone No _____

OR
STAMP

Optometrist/Contact Lens Practitioner Signature _____

Date _____

Once complete please send your specification either by:

Post **Boots Opticians Contact Lenses Online, FREEPOST NAT12429, Glasgow, G2 2BR**

Fax **0845 604 8326**

Email **support@bootscontactlensesonline.com**

If you have any queries please contact our customer helpline on 0845 604 8420 (Mon – Fri 9am – 6pm)