

Fax

To: Denise Ebanks From: _____

Fax: 504-454-2142 Pages: 1

Phone: _____ Date: _____

Re: Lenses Needed CC: _____

Urgent For Review Please Comment Please Reply Please Recycle

● Comments:

Patient Name: _____

Patient DOB: _____

Date of Surgery: _____

ANTERIOR	A-CONSTANT	POWER
MTA 4UO	115.30	