

## 100 Johnson Avenue Hackensack, NJ 07601

Tel: 201-535-4300 www.icadlaboratory.com

For Lab Use Or	nly			
Order Date:			Due Date:	
Dr. Name:			License #:	
Practice Name	:			
Patient Name	Please Print):			
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	☐ Bags 🦰	☐ R <sub>x</sub> Pads	☐ Mailin	



I agree full remittance of charges incurred by this prescription is payable within fifteen days of receipt of statement and further agree to pay all costs incurred in collection should I default, including without limitation, reasonable attorneys fees and a monthly service charge of two percent of outstanding balance.



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Shade  Posterior Occl. Stain	R (5)	R 32 12 13 14 15 16 16 17 18 19 19 19 19 19 19 19 19 19 19	17 18 19 19 19 19 19 19 19 19 19 19 19 19 19
Please print detailed instruc	tions to avoid processing errors:		
We Need: Bags	☐ R <sub>x</sub> Pads	☐ Mailing L	abels 📮

Doctor Signature:

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