



Patient Support Tools

ORDER FORM

Date: _____

Please send the following to: _____

_____ Patient Brochures (packs of 100)

_____ “How to take your *Macula Therapy Formula™*” cards (50)

_____ Recall Cards (packs of 50)

_____ Rx Pads (50 each)

Please write name, address & phone exactly as you wish it to appear:

_____ Autoship/ Order Form Pads (50 each)

If there are any questions, *Vision Vitamins, Inc.* should contact:

_____ at (_____) _____-_____.

Please fax Order Forms to: 888-610-2040