

HAUS CALL TELELOWVISION PROGRAM Product Trial Kit Order Form

Account #:	Purchase Order #:		
Account Name:	Date:		
Placed by:	Phone:		
Doctor or staff member to conta	act with passwords and/or Tele	elowvision Pro	gram review (required):
Name:	Email:		
Shipping Information			
Patient Name:	Patient Phone:		
Street Address:	Unit #		
City:	State:		Zip:
Preferred date of virtual appoint	ment (must be min. of 10 bus	siness days aft	er date of order):
Ship via: ☐ Regular (regu	lar shipping included in pr	ice)	
Other shipping options (surchar	ge applies): □ 3-day □ 2-d	ay 🗆 Overni	ight AM □ Overnight PM
Product Trial Kit Option	ons – Check One		
☐ Product Trial Kit with opti	ional iPad (#TLV-2P)	With iPad	Without iPad (Check one)
☐ Product Trial Kit previous	ly purchased as part of a C	omplete Sys	tem
Please provide Sales Ord	er #		
Special Instructions:			
Products For Kit			
Product Number	Bracketing* if Possible?		Notes
	□ Yes □ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

□ Yes □ No	
□ Yes □ No	

^{*}Bracketing involves offering a similar device one unit of measure stronger and lower than that ordered to allow for any variances in the needs required for the object(s) being viewed. For absorptive filters, different frame sizes or tints will be used.

Once form is completed, save and submit to customerservice@eschenbach.com

www.eschenbach.com | (800) 487-5389