OPHTEC

focus on perfection

ARTIFLEX® Toric Refractive Lenses

Faxnumber: 0031-50-5254386

Surgeon: * …… **Faxnumber or e-mail: *** …… ……	**Patient name: *** …… **Date of birth:** ……	
	Right (OD)	**Left (OS)**
Vertex: standard 12 mm	**If other:**	**If other:**
Subjective refraction **Sphere *** **Cylinder *** **Axis ***	……dpt. ……dpt. ……°	……dpt. ……dpt. ……°
K-values K1 * **K2 ***	……dpt. …… dpt.	…… dpt. ……dpt.
A.C. Depth * **From epithelium ☐** **or** **From endothelium ☐** **Pseudophakic ☐**	……mm.	……mm.
Postoperative target	**Sphere**……dpt. **Cylinder**……dpt.	**Sphere**……dpt. **Cylinder**……dpt.
Orientation of incision (*Lens position*) **Superior is standard**	☐ **Superior incision (*horizontal*)** ☐ **Temporal incision (*vertical*)**	☐ **Superior incision (*horizontal*)** ☐ **Temporal incision (*vertical*)**
Remarks: …… …… …… …… …… ……		
Please note: * is mandatory information		
Date: ……		