OPHTEC

focus on perfection

ARTISAN® Spherical Refractive Lenses

Faxnumber: 0031-50-5254386

Surgeon: * ……	**Patient name: *** ……	
Faxnumber or e-mail: * …… ……	**Date of birth: ……**	
	Right (OD)	**Left (OS)**
Vertex: standard 12 mm	**If other: ……..**	**If other: ……..**
<u>Subjective refraction</u> **Sphere *** **Cylinder ***	**……..dpt.** **……..dpt.**	**……...dpt.** **……...dpt.**
<u>K-values</u> K1 * **K2 ***	**……...dpt.** **……..……dpt.**	**……...dpt.** **……...dpt.**
<u>A.C. Depth</u> * **From epithelium ☐** **or** **From endothelium ☐** **Pseudophakic ☐**	**……..mm.**	**……..mm.**
Postoperative target	**……...dpt.**	**……..dpt.**
Type of ARTISAN® PIOL to be supplied	**Myopia 5/7.5 - ref 202** **Myopia 6/8.5 - ref 204** **Myopia 5/8.5 - ref 206** **Hyperopia 5/8.5 - ref 203**	**Myopia 5/7.5 - ref 202** **Myopia 6/8.5 - ref 204** **Myopia 5/8.5 - ref 206** **Hyperopia 5/8.5 - ref 203**
Remarks: …… …… …… …… ……		
Please note: * is mandatory information		
Date:……		