OPHTEC

focus on perfection

ARTISAN® Toric 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 *** **Axis ***	……..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	**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: ……		