

SPHERICAL ARTISAN[®] 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:
<u>Subjective Refraction</u>		
Sphere **	.....dpt	.....dpt
Cylinder **	.....dpt	.....dpt
<u>K-Value</u> K1 **	.....dpt	..... dpt
K2 **	..... dpt	.....dpt
<u>A.C. Depth</u> **		
from Epithelium <input type="checkbox"/>		
or	.....mm	.....mm
from Endothelium <input type="checkbox"/>		
Pseudophakic <input type="checkbox"/>		
Postoperative Target	.....dpt	.....dpt
Type of ARTISAN [®] IOL 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:.....		