



AMERICAN ACADEMY™
OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.



K Card

Pre- & Post-operative
Refractive Surgery
Information

Please complete this form and give it to your patients
for their use in the event of future cataract surgery.

Patient name: _____

Date of surgery or retreatment: _____

Refractive surgeon name: _____

Surgeon phone: _____

Date of pre-operative readings: _____

Right eye pre-operative refraction: _____ sphere _____ cylinder _____ axis
at vertex distance _____ mm

Left eye pre-operative refraction: _____ sphere _____ cylinder _____ axis
at vertex distance _____ mm

Right eye pre-operative keratometry: _____(D)K1 _____(D)K2

Left eye pre-operative keratometry: _____(D)K1 _____(D)K2

Intended refractive correction: _____ right eye _____ left eye

Right eye post-operative refraction: _____ sphere _____ cylinder _____ axis

Left eye post-operative refraction: _____ sphere _____ cylinder _____ axis