

REQUEST FOR OCULAR TISSUE FORM

TO BE COMPLETED WHEN REQUESTING TISSUE FOR TRANSPLANT.
PLEASE COMPLETE THIS FORM AND FAX IT TO 608.338.0044.
IF YOU HAVE QUESTIONS, CALL 877.233.2354 EXT. 2

PATIENT INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Age: _____ Sex: _____

Patient ID number (MRN, SSN, etc.): _____

Diagnosis Category: _____

See Diagnosis Category Worksheet for further guidance on how to assign a patient's Diagnosis Category.

SURGERY INFORMATION

Surgeon Name: _____

Surgery Location: _____ City: _____

Surgery Date: _____ Surgery Time (approx.): _____ AM PM (circle one)

TISSUE TYPE BEING REQUESTED

EYE BANK PROCESSED TISSUES

- DSAEK
- Ultra-thin DSAEK
 - Preferred Graft Thickness _____
- DMEK
 - Preload
- LAK/IEK
- DALK/ALK
- Long-term cornea in glycerin:
 - Immediate use Stock: _____ *Quantity*
- Other: _____

UNPROCESSED TISSUES

- PKP
- LKP/Tectonic
- DALK/ALK
- K-pro
- KLA
- Whole sclera Quarter sclera
 - Immediate use Stock: _____ *Quantity*
- DSEK (to be dissected by Surgeon)
- DMEK (to be dissected by Surgeon)

See Available Tissue Types Worksheet for further guidance.

SPECIAL REQUESTS/COMMENTS

HOW TO SUBMIT TISSUE REQUEST

Please submit this form to LEBW by faxing to 608.338.0044. We will contact you to confirm receipt of this form on the same business day it is received.

If you do not receive a confirmation from us, please call us at 608.233.2354 ext. 2.

If applicable to your facility, submit Purchase Orders by faxing to 608.338.0044