BEAUTY OF SIGHT
A LIONS EYE BANK

TISSUE REQUEST FORM

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SURGEON INFORMATION:

DATE OF REQUEST:	SURGERY DATE AND TIME:	SURGERY LOCATION:
SURGEON NAME:	*CONTACT NAME:*	
EMAIL TO SEND CONFIRMATION:	PHONE:	FAX:

PATIENT INFORMATION:

LAST NAME:	FIRST NAME:			
DATE OF BIRTH:	AGE:	SEX:	RACE:	ID # (MR OR SS):
ADDRESS:	CITY:	STATE:	ZIP CODE:	

DIAGNOSIS:

- ☐ POST CATARACT SURGERY EDEMA
- ☐ ECTASIAS/THINNINGS
- ☐ ENDOTHELIAL DYSTROPHIES
- ☐ REPEAT CORNEAL TRANSPLANT
- ☐ OTHER DEGENERATIONS OR DYSTROPHIES
- ☐ POST REFRACTIVE SURGERY
- ☐ MICROBIAL KERATITIS
- ☐ MECHANICAL OR CHEMICAL TRAUMA
- ☐ CONGENITAL OPACITIES
- ☐ PTERYGIUM
- ☐ NON-INFECTIOUS ULCERATIVE KERATITIS OR PERFORATION
- ☐ OTHER CAUSES OF CORNEAL OPACIFICATION OR DISTORTION
- ☐ OTHER ENDOTHELIAL DYSFUNCTION
- ☐ OTHER NON ENDOTHELIAL DYSFUNCTION
- ☐ NON-CORNEA RELATED:_____

SURGICAL PROCEDURE:

- ☐ PKP (PENETRATING KERATOPLASTY)
- ☐ DSAEK OR DLEK (DESCEMET STRIPPING OR DEEP LAMELLAR)
- ☐ DMEK (DESCEMET MEMBRANE ENDOTHELIAL KERATOPLASTY)
- ☐ DALK (DEEP ANTERIOR LAMELLAR KERATOPLASTY)
- ☐ SALK (SUPERFICIAL ANTERIOR LAMELLAR KERATOPLASTY)
- ☐ OTHER ALK (PERIPHERAL, ECCENTRIC, ETC.)
- ☐ KLAL (KERATOLIMBAL ALLOGRAFT)
- ☐ TECTONIC FULL THICKNESS
- ☐ K-PRO (KERATOPROTHESIS)
- ☐ GLAUCOMA SHUNT PATCH OR OTHER NON-KP USE
- ☐ ENUCLEATION
- ☐ OTHER: _____

REQUIRED TISSUE:

FRESH TISSUES:

☐ CORNEA FULL THICKNESS OPTICAL ☐ CORNEA FULL THICKNESS THERAPEUTIC ☐ WHOLE GLOBE (MOIST CHAMBER)

☐ CORNEA PRE-CUT FOR DSAEK: THICKNESS_____ MARKINGS_____ ☐ PRELOADED: PUNCH SIZE_____

☐ CORNEA PEELED FOR DMEK: MARKINGS_____ PUNCH SIZE _____ ☐ PRELOADED

☐ CORNEA FOR CAIRS: ☐ CUSTOMIZED ☐ NON-CUSTOMIZED PUNCH SIZE_____

OTHER INSTRUCTIONS:_____

LONG TERM PRESERVED TISSUES:

IRRADIATED CORNEA: ☐ HALF MOON SCLERA IN ALCOHOL: ☐ WHOLE ☐ QUARTER (¼) ☐ EIGHTH (⅛)

SHIP TISSUE TO:	SHIP VIA:
BILLING ADDRESS:	PO#: