Transplant Tissue Request Form

(Form must be completed before request will be processed)

Please fax completed form to (720) 848-3947 or scan and email to distribution@corneas.org. For questions contact us at (720) 848-3959.

ROCKY MOUNTAIN LIONS EYE BANK

Recipient Information

First Name: _____ Last Name: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Gender: _____ ID# (SS, DL or Med Rec#): _____

Planned Surgery: **Receiving Eye: OD OS**

- ☐ Glaucoma Patch/Shunt Cover ☐ Fresh ☐ Long-term Preserved
- ☐ Penetrating Keratoplasty (PKP)
- ☐ Keratolimbal Allograft (KLAL)
- ☐ Anterior Lamellar Keratoplasty (ALK) OR ☐ Deep Anterior Lamellar Keratoplasty (DALK)
- ☐ Intralase Enabled Keratoplasty (IEK)
  (circle appropriate answer)
  Pre-sectioned? ☐ Yes | ☐ No
  Circle desired tissue shape if "Yes" for pre-sectioned tissue: ☐ zig-zag | ☐ top hat | ☐ mushroom
- ☐ Posterior Lamellar / EK, DSAEK, DSEK, DMEK
  Pre-sectioned? Yes | No
  Indicate preferred sectioning procedure and thickness goal for selected tissue.
  - ☐ **DMEK (pre-sectioned only)** ☐ ☐ No Stromal Mark
  - ☐ **DSEK/DSAEK Standard (above 100 only):** _____ µm (+/- 20µm)
    or
  - ☐ **DSEK/DSAEK Ultra-thin (between 50-90 only):** _____ µm (+/- 20µm) ***(Ultra-thin grafts carry additional charges.)***

DSEK/DSAEK: Stardard is to include ALL marks shown below (*PLEASE INDICATE DESIRED MARKS BELOW IF YOU DO NOT WANT OUR STANDARD MARKS*)

☐ **"S" Direction Mark on Stromal Bed**

☐ **Central Epithelial Mark**

☐ **Bed Diameter Marks**

☐ **Other or No Marks**

- ☐ Sclera (whole)

Pre-Operative Diagnosis: (please check appropriate box)

☐ Post-Cataract Surgery Edema	☐ Keratoconus	☐ Fuch's Dystrophy
☐ Repeat Corneal Transplant	☐ Other Degenerations/Dystrophies	☐ Post-Refractive Surgery
☐ Microbial Changes	☐ Mechanical or Chemical Trauma (non-surgical)	☐ Congenital Opacities
☐ Other Causes of Corneal Opacification or Distortion		

Surgery Information

Surgery Site: _____ Surgeon: _____

Surgery Coordinator: _____ Request Date: _____ Surgery Date: _____ Surgery Time: _____

PO # (if applicable): _____ Phone: _____ Fax: _____ Email: _____

Special Notes: _____

RMLEB OFFICIAL USE ONLY: Request recorded by: Date/time: Request#: