ROCKY MOUNTAIN LIONS EYE BANK
Share the circle of light
Phone: 720-848-3937 Toll-free: 800-444-7479

Request for Ocular Tissue for Research and Training

Name of physician making request: _____

Telephone:_____ Fax:_____ Pager:_____Email: _____

☐ Check here if a current resident at the University of Colorado Health Sciences Center

☐ Check here if current faculty or staff at the University of Colorado Health Sciences Center

Use of tissue:_____

Is this a funded research project? ☐ YES ☐ NO

Date tissue is needed: _____

If outside of the Denver metropolitan area, list shipping instructions: (Shipping fees apply)

_____

_____

_____

Tissue Requested (circle all that apply and indicate quantity and special instructions):

TISSUE	QUANTITY	LENS PREFERENCE	SPECIAL REQUIREMENTS
Fresh Whole Globe		□ aphakic □ pseudophakic □ phakic □ no preference	
Cornea		□ aphakic □ pseudophakic □ phakic □ no preference	
Other:		□ aphakic □ pseudophakic □ phakic □ no preference	

□ Check here if donor serology is required. List necessary tests (provided with additional fees. Fee schedule available on request):_____

_____ _____

Signature *Date*

_____ _____

Faculty Signature (Required for requests from ophthalmology residents) *Date*

PLEASE FAX THIS COMPLETED FORM TO 720-848-3947