



Transplant Tissue Request Form

Form must be completed before request will be processed.

Fax completed form to 720-848-3947 or email to distribution@corneas.org

Questions? Call 720-848-3959

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

<input type="checkbox"/> Glaucoma Patch/Shunt Cover	<input type="checkbox"/> Fresh	<input type="checkbox"/> Long-term Preserved
<input type="checkbox"/> Penetrating Keratoplasty (PKP)		
<input type="checkbox"/> Keratolimbal Allograft (KLAL)		
<input type="checkbox"/> Anterior Lamellar Keratoplasty (ALK) OR <input type="checkbox"/> Deep Anterior Lamellar Keratoplasty (DALK)		
<input type="checkbox"/> Intralase Enabled Keratoplasty (IEK)		
Pre-sectioned? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes" for pre-sectioned tissue, select desired tissue shape: <input type="checkbox"/> zig-zag <input type="checkbox"/> top hat <input type="checkbox"/> mushroom		
<input type="checkbox"/> Posterior Lamellar / EK, DSAEK, DSEK, DMEK		
Pre-sectioned? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Indicate preferred sectioning procedure and thickness goal for selected tissue.		
<input type="checkbox"/> DMEK (pre-sectioned only)	<input type="checkbox"/> 	<input type="checkbox"/> No Stromal Mark
<input type="checkbox"/> DSEK/DSAEK Standard (above 100 only): _____ μm (+/- 20 μm)		
or		
<input type="checkbox"/> DSEK/DSAEK Ultra-thin (between 50-90 only): _____ μm (+/- 20 μm) (<i>Ultra-thin grafts carry additional charges.</i>)		
DSEK/DSAEK: Standard is to include ALL marks shown below. Please indicate desired marks if you do NOT want all standard marks.		
<input type="checkbox"/> "S" Direction Mark on Stromal Bed 	<input type="checkbox"/> Central Epithelial Mark 	<input type="checkbox"/> Bed Diameter Marks 
		<input type="checkbox"/> Other or No Marks 
<input type="checkbox"/> Sclera (whole)		

Pre-Operative Diagnosis

<input type="checkbox"/> Post-Cataract Surgery Edema	<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Fuch's Dystrophy
<input type="checkbox"/> Repeat Corneal Transplant	<input type="checkbox"/> Other Degenerations/Dystrophies	<input type="checkbox"/> Post-Refractive Surgery
<input type="checkbox"/> Microbial Changes	<input type="checkbox"/> Mechanical or Chemical Trauma (non-surgical)	<input type="checkbox"/> Congenital Opacities
<input type="checkbox"/> 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#: _____
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