Transplant Tissue Request Form

Form must be completed before request will be processed.

Fax completed form to 720-925-5669 or email to distribution@corneas.org

Questions? Call 720-550-8116

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)

Pre-sectioned? ☐ Yes ☐ No

If "Yes" for pre-sectioned tissue, select desired tissue shape: ☐ 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 if you do NOT want all standard marks.

☐ **"S" Direction Mark on Stromal Bed** ☐ **Central Epithelial Mark** ☐ **Bed Diameter Marks** ☐ **Other or No Marks**

☐ Sclera (whole)

Pre-Operative Diagnosis

☐ 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#: