Transplant Tissue Request Form

(Form must be complete before request will be processed)

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

Recipient Information:

First Name:____________________ Last Name:____________________

Address:____________________ City/State/Zip:____________________

Date of Birth:__________ Age:______ Gender:_____ Ethnicity:__________ ID # (SS, DL or Med Rec #):______________

Planned Surgery (please circle the appropriate options): **Receiving Eye:** OD OS

Procedure/Tissue Requirements:

❒ **Penetrating Keratoplasty (PKP)**	❒ **Anterior Lamellar Keratoplasty (ALK) or Deep Anterior Lamellar Keratoplasy (DALK)**	❒ **Posterior Lamellar, DSAEK or EK** ***Pre-Sectioned ?*** Yes or No **Check preferred thickness for pre-sectioned tissue:** **Single pass:** ❒ 100-130 µm ❒ 135-150 µm ❒ >150 µm ***Double Pass:** ❒ 50-80 µm ❒ 85-110 µm **Ultra-thin, double pass grafts carry an extra charge. Available in USA only.*
❒ **Keratolimbal Allograft (KLAL)**	❒ **Sclera**	❒ **Intralase Enabled Keratoplasty (IEK)** ***Pre-Sectioned***? Yes or No **Circle shape for pre-sectioned tissue:** zizag | top hat | mushroom

Pre-Operative Diagnosis: (Please Circle)

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	

Surgeon Information*:*

Surgery Site:____________________ Surgeon:____________________

Sx Coordinator:______________ Request Date:__________ Surgery Date:__________ Surgery Time:__________

PO# (If applicable):____________ Phone:______________ Fax:____________ Email:________________

**Special Notes____

RMLEB OFFICE USE ONLY: Request recorded by:________ Date/Time:________ Request #:______________