CorneaGen™
1200 6th Ave., Ste 300, Seattle, WA 98101

Phone: +1.206.682.8502
Fax: +1.206.682.8504
Email: tissue@corneagen.com

International Surgical Tissue Request Form

Surgeon: _____ Today's Date: _____

Contact Person: _____ Phone #: _____

Email: _____ Fax: _____

Surgery Facility Name: _____

Ship Tissue to:
(if different than above) _____

Surgery Date: _____ Requested Arrival Date: (at airport) _____

Except for emergencies, please try to give at least 10 days notice

Special Concerns or PO: _____

Add Ampho B: ☐Yes ☐No

Cornea surgery type:
(select one box only)

PKP (full thickness): ☐			Other ALK: ☐
			DALK: ☐
DSAEK / DSEK:	Pre-cut: ☐	Surgeon will cut: ☐	KLAL: ☐
DMEK:	Pre-cut: ☐	Surgeon will cut: ☐	K-Pro: ☐

OR

Other tissue types: ¼ Sclera: ☐ Whole Sclera: ☐ Whole Globe: ☐ Glycerin Preserved Cornea: ☐

Surgery type for other tissue types:

Please complete Patient information in full (required by EBAA Medical Standards)

Patient Name: _____

Date of Birth: _____ Age: _____

SSN or Patient ID: _____ Male: ☐ Female: ☐

Pre-Op Diagnosis: _____ OD: ☐ OS: ☐

Other Diagnosis: _____

Emergency Contact: Email tissue@corneagen.com or call 877-716-3589, ask for CorneaGen

1. Please fax scheduled requests at least 7 days prior to the requested delivery date.
2. Please notify CorneaGen of any schedule changes by emailing tissue@corneagen.com
3. Emergent / urgent requests should be noted in the "Special Concerns" box, above.

Email address for confirmation (if different than email above): _____