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

24 hr Phone: 206.682.8502
or 877.682.8502
FAX: 206.682.8504
Email: tissue@corneagen.com

Bio-Tissue® Surgical Tissue Request Form

Your Name: ______________________________

Phone number: ______________________ Today's Date: ______________

Name of Surgery Facility: ______________________________

Transplanting Surgeon: ______________________________

Surgery Date and Time: ______________________________

Requested Delivery Date: ______________________________

PO Number (if applicable): ______________________________

# Requested	Catalog No.	Description
	AG1510	AmnioGraft® 1.5 x 1.0 cm
	AG2015	AmnioGraft® 2.0 x 1.5 cm
	AG2520	AmnioGraft® 2.5 x 2.0 cm
	AG3535	AmnioGraft® 3.5 x 3.5 cm
	AG5050SJ	AmnioGraft® 5.0 x 5.0 cm (for Stevens-Johnson syndrome patients)
	AG10050	AmnioGraft® 10.0 x 5.0 cm
	AGD1075	AmnioGuard™ 1.0 x 0.75 cm (for glaucoma shunt tube covering)
	PK16	PROKERA® Biologic Corneal Bandage
	PKS	PROKERA® SLIM Biologic Corneal Bandage
	PKP	PROKERA® PLUS Biologic Corneal Bandage
	PKCLR	PROKERA® CLEAR Biologic Corneal Bandage

Patient Name: ______________________________

Date of Birth or Age: ______________________ Eye Involved: ______________

Medical Record # or Pt ID #: ______________________________

Comments/ Concerns: ______________________________

1. Please fax scheduled requests at least 7 days prior to the requested delivery date.
2. Emergent / urgent requests should be phoned directly to a CorneaGen Coordinator and then followed up with a Tissue Request Form

Please provide your fax number for confirmation fax: ______________________

Fax received by: ______________________