CorneaGen	Adverse Reaction Questionnaire- Transplant Surgeon	Document No.:	QF-515-01
		Revision:	6
		Revision Date:	08/19/2021
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Donor Tissue # _____ Surgeon Name _____ Surgeon Contact Number/Email _____ Surgical Facility _____

Patient Name _____ Date of Birth _____ Pre-Operative Diagnosis _____ Date of Surgery _____

(Check One)

☐ **Adverse Reaction** probably **NOT** due to donor tissue **(skip to signature line)**

OR

☐ **Adverse Reaction** probably **DUE TO** donor tissue **(complete questions below)**

1. Did pre-existing ophthalmic condition exist that increased opportunity for adverse outcome? ☐ Yes ☐ No
2. Date of Adverse Reaction Diagnosis? _____
3. Cultures Performed? If yes, please submit copies of all available culture and sensitivity reports.

	NOT PERFORMED	PERFORMED	SOURCE	RESULTS
Donor	☐	☐	Corneal Scleral Rim	
	☐	☐	Corneal Storage Media	
Patient	☐	☐	Aqueous Humor	
	☐	☐	Vitreous Humor	

4. Did the cornea ever clear post operatively? ☐ Yes ☐ No
5. Was there any useful vision post operatively? ☐ Yes ☐ No
6. Did surgical manipulation have a role in the graft failure? ☐ Yes ☐ No
7. If EK, did the tissue dislocate? ☐ Yes ☐ No
8. If EK, was the tissue rebubbled? ☐ Yes ☐ No
9. Regraft necessary? ☐ Yes ☐ No Date of regraft? _____
10. Type of Adverse Reaction (Infection vs Biologic Dysfunction)

☐ Endophthalmitis ☐ Keratitis ☐ Evidence Suggestive of Prior Refractive Surgery

☐ Graft Failure ☐ Transmission of Systematic Disease ☐ Other: _____

Physician Comments: _____

_____

Name/Signature of Person Completing Form Date