CorneaGen™

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Bio-Tissue® Surgical Tissue Request Form

Surgeon Name: _____ Today's Date: _____

Contact Person: _____ Phone Number: _____

Surgery Facility Name: _____

Ship To Address: _____

PO # (REQUIRED): _____

PO required to ship and must include $190 service charge per item and shipping fee ($100 via FedEx or $200 via courier)

Surgery Date: _____ Surgery Time: _____

Delivery Date: _____ Delivery Time: _____

BioTissue® must be delivered the day of procedure, unless facility has license on file with CorneaGen to store tissue.

# 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: _____

Patient Age: _____ Patient Medical Record Number or ID: _____

Eye Involved: ◯ OD ◯ OS

Special Concerns: _____

1. Please notify CorneaGen of any schedule changes by submitting a revised request form.
2. Emergent / urgent requests should be submitted directly via e-mail/fax, followed up by a phone call.

Please provide your fax number or e-mail address for confirmation: _____

Received by: _____
CorneaGen Staff & Date