CorneaGen™

24-Hr Ph: 877.682.8502
Fax: 206.682.8504
E-mail: tissue@corneagen.com

BrightMEM™ 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

Surgery Date: _____ Surgery Time: _____

Delivery Date: _____ Delivery Time: _____

CorneaGen requests 10 day lead time from order submission to surgery to process and provide BrightMEM™ tissue.

	Catalog No.	Description
☐	K018-AK-BMAK	BrightMEM Anterior Lamellar Keratoplasty (BMAK) Allograft

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 emailing or submitting a revised request form.
2. Emergent / urgent requests should be submitted directly via e-mail, followed up by a phone call.

Please provide your e-mail address for confirmation: _____

Received by: _____
CorneaGen Staff & Date