

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): <input type="checkbox"/>	Other ALK: <input type="checkbox"/>
	DSAEK / DSEK: Pre-cut: <input type="checkbox"/> Surgeon will cut: <input type="checkbox"/>	DALK: <input type="checkbox"/>
	DMEK: Pre-cut: <input type="checkbox"/> Surgeon will cut: <input type="checkbox"/>	KLAL: <input type="checkbox"/>
		K-Pro: <input type="checkbox"/>

OR

Other tissue types:	Whole Sclera <input type="checkbox"/>	Whole Globe <input type="checkbox"/>
Surgery type for other tissue types:		

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

Patient Name: _____

Patient Medical Record Number or ID: _____ Age: _____

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): _____