

Surgeon Name	Surgical Facility
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Donor Tissue ID	Patient Last Name	Pre-Operative Diagnosis	Surgery Date
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Check One:	
<input type="checkbox"/> Adverse reaction probably NOT due to donor tissue. (Skip to signature line)	<div style="border: 1px solid black; padding: 5px; display: inline-block; font-weight: bold;">OR</div> <input type="checkbox"/> Adverse reaction probably DUE TO donor tissue. (Complete questions below)

RECIPIENT INFORMATION	1. Did a pre-existing ophthalmic condition exist that increased opportunity for adverse outcome? *If "Yes," specify: _____	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	2. Date of Adverse Reaction Diagnosis?	DATE:	
	3. Was the patient compliant with post-op orders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Has this patient had previous transplants (whether supplied by CG or not)? *If "Yes," please provide details: _____	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	5. How was the patient's health on the day of surgery?		
GRAFT INFORMATION	6. Did the cornea clear after eight (8) weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. Did surgical manipulation have a role in the graft failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	8. If EK, did the tissue dislocate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9. If EK, was the tissue re-bubbled? *If "Yes," how many times? _____	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	10. Date of regrant or planned date, if applicable.	DATE:	
	11. Type of Adverse Reaction (Infection vs. Biologic Dysfunction): <input type="checkbox"/> Graft Failure <input type="checkbox"/> Keratitis <input type="checkbox"/> Endophthalmitis <input type="checkbox"/> Other: _____		
TISSUE	12. Did the tissue arrive with a tamper evident seal and vial intact without leaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	13. Was the preservation media optically clear and in a liquid state (not frozen)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	14. Did the tissue arrive cooled with ice present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	15. How was the tissue stored after it was received and until time of surgery? <input type="checkbox"/> Kept in box with wet ice. <input type="checkbox"/> Placed in a 2-8°C refrigerator. <input type="checkbox"/> Other: _____		

Cultures Performed? If so, please submit copies of all available culture and sensitivity reports.				
	Not Performed	Performed	Source	Results
Donor	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Scleral Rim	
	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Storage Media	
Patient	<input type="checkbox"/>	<input type="checkbox"/>	Aqueous Humor	
	<input type="checkbox"/>	<input type="checkbox"/>	Vitreous Humor	

Surgeon Comments (Optional):

Printed Name of Person Completing Form	Date
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