TISSUE REQUEST FORM: CTAK

CorneaGen

1200 6th Avenue, Suite 300
Seattle, WA 98101
Phone 206-682-8502 | Fax 206-682-8504

CONTACT INFORMATION

SURGEON _____

SURGICAL FACILITY _____

Facility Address _____

City _____ State _____ Zip _____

REQUESTOR'S NAME _____

REQUESTOR'S PHONE _____

SHIPPING INFORMATION - Please allow at least **three (3)** weeks of lead time for processing.

SURGERY DATE _____

SURGERY TIME _____

PURCHASE ORDER REQUIRED? ◯ Yes ◯ No

IF "YES," PROVIDE _____

PATIENT INFORMATION

PATIENT NAME _____

MEDICAL RECORD NUMBER _____ AGE _____

PRE-OPERATIVE DIAGNOSIS _____ EYE INVOLVED ◯ OD ◯ OS

CTAK DETAILS

OUTER DIAMETER _____ ARC LENGTH _____

INNER DIAMETER _____ PREFERRED THICKNESS _____

REQUIRED: DID YOU INCLUDE PATIENT'S CTAK SURGICAL PLAN WITH THIS REQUEST? ☐ YES

INSTRUCTIONS

1. Please e-mail this request to tissue@corneagen.com or fax it to 206-682-8504.
2. After receiving and processing your request, confirmation will be sent to you via fax or e-mail.

   If confirmation should be sent via fax, please include return fax number: _____
3. CTAK is a custom processed tissue. Due to the special customizations, returns, exchanges, and cancellations after tissue has been processed are not permitted and facility/surgeon shall be responsible for payment.

FOR INTERNAL USE

To be filled out by CorneaGen and returned as confirmation that we have received your request:

CorneaGen Staff & Date _____

Please retain this form for processing purposes.

Please complete and return to tissue@corneagen.com.