Tissue Request Form

Please complete the Patient Information in full, as it is required by EBAA Medical Standards

Requesting Surgeon: _____

Date of Surgery: _____ Time of Surgery: _____

Recipient Name: _____

Date of Birth/Age: _____ SSN/MRN#: _____

Diagnosis: _____ ☐ OS ☐ OD

Type of Graft:

- ☐ PKP
- ☐ EK **Is custom eye bank processed tissue requested**? ☐ Yes ☐ No
  Please specify: ☐ DSEK ☐ DMEK ☐ DMAEK
- ☐ LAK **Is custom eye bank processed tissue requested?** ☐ Yes ☐ No
- ☐ ALK **Is custom eye bank processed tissue requested?** ☐ Yes ☐ No
- ☐ K-Pro
- ☐ Tectonic *(Emergency Patch)*
- ☐ Long Term Preserved Corneas ☐ ½ ☐ Whole
- ☐ Sclera ☐ ¼ ☐ ½ ☐ Whole
- ☐ Amniotic Membrane ☐ 1.5 x 1.0 ☐ 2.0 x 1.5 ☐ 2.5 x 2.0 ☐ 3.5 x 3.5 ☐ 5.0 x 5.0

Please List any Specifications or Special Requests: _____

_____

Name of Surgery Location: _____ P.O: _____

Surgery Location Address: _____

Request Submitted By: _____ Date & Time: _____

Phone Number: _____ Fax Number: _____

Upon completion, please email to dc@visionshare.org OR fax to 888.657.4410.

The Vision Share Distribution Center may be reached 24 hours a day, 7 days a week at 888-65-SIGHT (888.657.4448)