A Donate Life Organization

Accredited Member of the Eye BankAssociation of America

Tissue Request Form

Request Date / Time: ______________________ **Surgeon:** ____________________

Surgery Information:

Date: ______________ Time**:** ________ Location: ______________________________

Patient Information:

First Name: ________________________ Last Name:_____________________________

Gender: ☐ M ☐ F Date of Birth: ______________ Age: _____

Eye to be grafted: ☐OD ☐ OS

SSN or ID #: ________________________ Pre-Op Diagnosis: _______________________
(Please indicate which type of ID if not SSN) (Please do not use insurance codes)

Corneal Tissue Requested:

☐ PKP ☐ LKP / AKP ☐ ALK ☐ EK ☐ IEK ☐ Boston-K

Processing Options: ☐ EK ☐ ALK ☐ DMEK ☐ IEK- cut type________ (Import tissue only)

Marks (optional): ☐ "S" stamp on periphery ☐ Central epithelial dot

☐ Other: _________________

Other Surgical Options

☐Whole Eye (LKP) ☐Half Sclera ☐Whole Sclera

Imported Tissue Acceptable? ☐ **Yes** ☐ **No**

For DNA Use Only:

Tissue Request Number: ______________ *Date Processed:* ____________

Email to osc@dnaz.org or Fax to 602-200-7931