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: ☐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 ☐ DSEK / DSAEK ☐ ALK ☐ K-Pro (patch graft)
☐ IEK ☐ DMEK ☐ DALK ☐ Other __________

Processing Options: ☐ ALK ☐ IEK-cut type______________________
(Tissue will be processed by the eye bank) ☐ DSEK / DSAEK (>80μm) ☐ Ultra-thin DSEK / DSAEK (<80μm)
☐ DMEK ☐ Pre-loaded DMEK ☐ Free Floating DMEK in vial

Marks (optional): ☐ "S" stamp ☐ Central epithelial dot
☐ Notch ☐ Other: _____________

Other Surgical Tissue: ☐ Whole Eye (LKP) ☐ Half Sclera ☐ Whole Sclera

☐ Glycerol Cornea ☐ Half ☐ Whole

Additional Comments: ____
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For DNA Use Only:
Tissue Request Number: ____________________ *Date Processed:* __________________________

Email to eyebank@dnaz.org or Fax to 602-200-7931.
Please contact Ocular Services at 602-222-2216 for any emergency surgery requests.