# TISSUE REQUEST FORM

**FLORIDA LIONS EYE BANK**
900 NW 17th Street Miami, FL 33136
Tel: (305) 324-4340
fax1 (305) 547-3692 fax2: (305) 326-6376
*flebdistribution@med.miami.edu*

C S CG WE

## SURGEON INFORMATION

| DATE OF REQUEST: | SURGERY DATE AND TIME: | SURGERY LOCATION: |
|---|---|---|
| | | |

| SURGEON NAME: | CONTACT NAME: |
|---|---|
| | |

| EMAIL TO SEND CONFIRMATION: | PHONE: | FAX: |
|---|---|---|
| | | |

## PATIENT INFORMATION

| LAST NAME: | FIRST NAME: |
|---|---|
| | |

| DATE OF BIRTH: | AGE: | SEX: | RACE: | ID # ( MR OR SS): |
|---|---|---|---|---|
| | | | | |

| ADDRESS: | CITY: | STATE: | ZIP CODE: |
|---|---|---|---|
| | | | |

## DIAGNOSIS

- □ POST CATARACT SURGERY EDEMA
- □ KERATOCONUS
- □ FUCH'S DYSTROPHY
- □ REPEAT CORNEAL TRANSPLANT
- □ OTHER DEGENERATIONS OR DYSTROPHIES
- □ POST REFRACTIVE SURGERY
- □ MICROBIAL CHANGES
- □ MECHANICAL OR CHEMICAL TRAUMA
- □ CONGENITAL OPACITIES
- □ PTERYGIUM
- □ NON-INFECTIOUS ULCERATIVE KERATITIS OR PERFORATION
- □ OTHER ENDOTHELIAL DYSFUNCTION
- □ OTHER NON ENDOTHELIAL DYSFUNCTION
- □ NON-CORNEA RELATED:_____

## SURGICAL PROCEDURE

- □ PKP (PENETRATING KERATOPLASTY)
- □ DSAEK OR DLEK (DESCEMET STRIPPING OR DEEP LAMELLAR)
- □ DMEK (DESCEMET MEMBRANE ENDOTHELIAL KERATOPLASTY)
- □ DALK (DEEP ANTERIOR LAMELLAR)
- □ SALK (SUPERFICIAL ANTERIOR LAMELLAR)
- □ OTHER ALK (PERIPHERAL, ECCENTRIC, ETC.)
- □ KLAL(KERATOLIMBAL ALLOGRAFT)
- □ TECTONIC FULL THICKNESS
- □ KERATOPROTHESIS (K-PRO)
- □ GLAUCOMA SHUNT PATCH OR OTHER NON-KP USE
- □ ENUCLEATION
- □ OTHER: _____

## REQUIRED TISSUE

- □ CORNEA (OPTICAL)
- □ CORNEA PATCH (THERAPEUTIC / TECTONIC)
- □ DSAEK (DESIRED THICKNESS_____)
- □ WHOLE GLOBE (MOIST CHAMBER)

***GLYCERIN PRESERVED TISSUE:***

CORNEA SIZE: □ WHOLE FULL THICKNESS □ WHOLE SPLIT THICKNESS □ HALF FULL THICKNESS □ HALF SPLIT THICKNESS

SCLERA SIZE: □ WHOLE □ QUARTER (¼) □ EIGHTH (⅛)

| SHIP TISSUE TO: | SHIP VIA: |
|---|---|
| | |

| BILLING ADDRESS: | PO#: |
|---|---|
| | |

FLEB ____/____/____ CONFIRMED