Lions Eye Bank of Delaware Valley

Tissue ID # : _____

TISSUE REQUEST – RECIPIENT INFORMATION FORM

PATIENT INFORMATION:

Patient Name:

_____

Sex: _____ **Race:** _____ **DOB:** _____ **Age:** _____

Social Security No. or Medical Record No.: _____

Street Address: _____

City, State, zipcode: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Eye Grafted: **OD** _____ **OS** _____

Keratoplasty Performed: Penetrating _____ **Epi** _____ **Lamellar** _____ **Other** _____

Previous Keratoplasties (include dates): _____

SURGEON -- TISSUE REQUEST INFORMATION:

Surgeon: _____

Office Contact: _____

Phone Number: _____ **Fax Number:** _____

Type of Tissue: **Cornea**

Circle Tissue Use: **PKP** **DSAEK** **DMEK** **Other:** _____

Date of Procedure: _____ **Time of Procedure:** _____

Hospital: _____

Purchase Order Number: _____

Special Requirements: _____

PLEASE FAX COMPLETED FORM AT LEAST ONE WEEK PRIOR TO SURGERY TO 215-563-6603. ALSO, PLEASE CALL TO CONFIRM THAT WE RECEIVED THIS FAX TO ENSURE THAT THE SURGERY IS NOTED ON THE SCHEDULE 215-587-9755. THANK YOU.