

Tissue ID # : _____

**LIONS EYE BANK OF DELAWARE VALLEY
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.