

Contact Information:

Surgeon Name _____

Surgeon Email _____ Surgeon DOB* _____

OK to Contact Surgeon: After Hours On Weekends By Text Cell _____ / _____

Average Transplants Performed Monthly _____ Surgery Days M T W Th F

Practice Name _____

Address _____

City _____ State _____ Zip _____

Surgical Coordinator (*requests tissue & receives tissue offers*) _____

Preferred Method of Contact: Email Phone Cell Fax Phone _____ / _____

Email _____ Cell _____ / _____ Fax _____ / _____

Surgical Facility No. 1:

**DOB is required when registering*

Surgical Facility Name _____

Delivery Address _____

City _____ State _____ Zip _____

Phone _____ / _____ Ext _____ Fax _____ / _____

Contact Name _____ Email: _____

Cell _____ / _____ PO Required? Yes No Delivery Hours _____ —

Billing Address (*if different than Delivery*) _____

City _____ State _____ Zip _____

Surgical Facility No. 2:

Surgical Facility Name _____

Delivery Address _____

City _____ State _____ Zip _____

Phone _____ / _____ Ext _____ Fax _____ / _____

Contact Name _____ Email: _____

Cell: _____ / _____ PO Required? Yes No Delivery Hours _____ —

Billing Address (*if different than Delivery*) _____

City _____ State _____ Zip _____

Space for additional surgical facilities on page 3.

Tissue Offer Preferences:

Maximum Death to Preservation Time (in hours) _____ Maximum Death to Surgery Time (in days) _____

Exclusionary Criteria (if any) _____

	PKP	DSAEK / UT DSAEK	DMEK / PDEK
Minimum Cell Density:	_____	_____	_____
Minimum Donor Age:	_____	_____	_____
Maximum Donor Age:	_____	_____	_____
Other Types of Surgeries Performed	_____		

Tissue Processing Preferences:

Preferences will be added to your profile and referenced when processing is requested. When custom preferences are necessary for a patient, simply indicate specifics on the tissue request form.

DSAEK

Thickness Range

Nano-Cut 40-70 μm Ultrathin 70-100 μm Traditional 100+ μm

Target Thickness _____ Processing capabilities are $\pm 25 \mu\text{m}$ of requested target.

Preloaded: Yes No Prestained: Yes No

If PRELOADED, choose preferred preloaded device and graft size:

LEITR DSAEK 3.0 DSAEK Endoglide

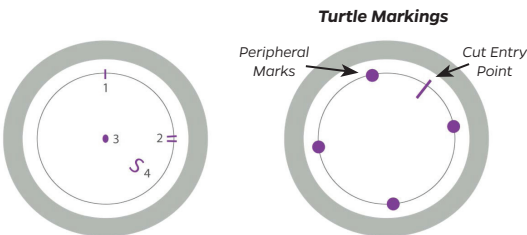
Graft size (in mm):

7.00 7.25 7.50 7.75 8.00 8.25 8.50 8.75

DSAEK Orientation Marking Options:

Please choose one or a combination of markings.

- 1 & 2. I - II (Anterior View)
- 3. Central dot on cap for cornea centration
- 4. "S" mark on stromal side of the graft
- 5. Turtle Markings
- 6. No Markings



DMEK / PDEK

Prestained: Yes No

Prepunched: Yes No

Preloaded: Yes No

If preloaded, choose preferred device below:

Preloaded in LEITR 2.0 Micro Jones Tube (2.0 - 2.2mm incision size)

Preloaded in Straiko Modified Jones Tube (2.6 - 3.2mm incision size)

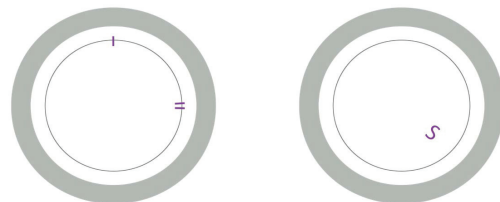
Preloaded in DMEK EndoGlide

If prepunched or preloaded, include graft size (in mm):**

7.00 7.25 7.50 7.75 8.00 8.25 8.50

DMEK / PDEK Orientation Marking Options:

I - II (Anterior View) "S" Stamp (Anterior View)



**PDEK graft size is determined by the anatomy. The window falls between 7.0-7.5mm and the average is 7.25mm.



Please save before sending completed forms to cornea@lionseyeinstitute.org or fax to 813.289.3600.

Surgeon Name _____

Surgical Facility No. 3:

Surgical Facility Name _____

Delivery Address _____

City _____ State _____ Zip _____

Phone _____ / _____ Ext _____ Fax _____ / _____

Contact Name _____ Email: _____

Cell: _____ / _____ PO Required? Yes No Delivery Hours _____ —

Billing Address (if different than Delivery) _____

City _____ State _____ Zip _____

Surgical Facility No. 4:

Surgical Facility Name _____

Delivery Address _____

City _____ State _____ Zip _____

Phone _____ / _____ Ext _____ Fax _____ / _____

Contact Name _____ Email: _____

Cell: _____ / _____ PO Required? Yes No Delivery Hours _____ —

Billing Address (if different than Delivery) _____

City _____ State _____ Zip _____

Surgical Facility No. 5:

Surgical Facility Name _____

Delivery Address _____

City _____ State _____ Zip _____

Phone _____ / _____ Ext _____ Fax _____ / _____

Contact Name _____ Email: _____

Cell: _____ / _____ PO Required? Yes No Delivery Hours _____ —

Billing Address (if different than Delivery) _____

City _____ State _____ Zip _____



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