Lions Eye Institute
FOR TRANSPLANT & RESEARCH
Leading Locally. Reaching Globally.

Surgeon Registration

1

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.

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Surgeon Registration 2

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
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 ± 25 µm of requested target.

Preloaded: ☐ Yes ☐ No Prestained: ☐ Yes ☐ No

If PRELOADED, choose preferred preloaded device and graft size:
☐ 3mm modified Jones Tube* ☐ DSAEK Endoglide

Graft size *(in mm):*
☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

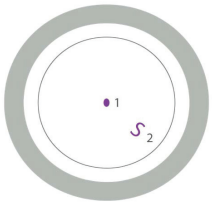
DSAEK Orientation Marking Options:
Please choose one or a combination of markings.

☐ **1.** central dot on cap for cornea centration

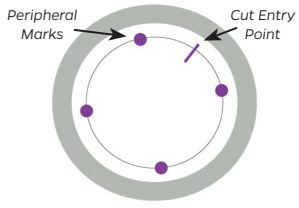
☐ **2.** "S" mark on stromal side of the graft

☐ **3.** Turtle Markings

☐ **4.** No Markings



Turtle Markings



DMEK

Prestained: ☐ Yes ☐ No

Prepunched: ☐ Yes ☐ No

Preloaded: ☐ Yes ☐ No

If preloaded, choose preferred device below:

☐ Preloaded in 2mm modified Jones Tube*

☐ Preloaded in Straiko modified Jones Tube*

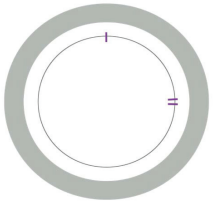
☐ Preloaded in DMEK EndoGlide

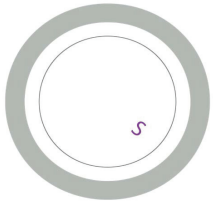
If prepunched or preloaded, include graft size (in mm):

☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50

DMEK Orientation Marking Options:

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





**Preloaded tissue in a modified Jones Tube is performed at the request of a surgeon and considered off-label use for cornea transplantation.*

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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