AltruVision
A Lions Eye Bank

TISSUE REQUEST FORM

Tissue ID # : _____

PATIENT INFORMATION :

Patient Name: _____

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

Social Security No. or Medical Record No.: _____

Street Address: _____

City, State, ZIP Code: _____

Primary Diagnosis: _____

Diagnosis Detail: _____

If Other: _____

Eye to be Grafted: OD ☐ OS ☐

Procedure (Choose One): ☐ PK ☐ K-Pro ☐ DALK ☐ DSAEK* ☐ DMEK** ☐ Other ***

Previous Keratoplasties (include dates): _____

*DSAEK: Thickness _____ um Markings: ☐ 4 Cardinal Points ☐ S-Stamp ☐ Other***

**DMEK: Pre-Punched Size: _____ mm AVAILABLE: 7.0mm, 7.25mm, 7.5mm, 7.75mm, 8.0mm, 8.25mm, 8.5mm

[DMEK tissue marked with orientating S-stamp and pre-loaded into Micro Weiss Glass Cannula, unless otherwise instructed]

SURGEON -- TISSUE REQUEST INFORMATION:

Surgeon: _____

Date of Procedure: _____ Time of Procedure: _____

Surgery Site: _____

Purchase Order Number: _____

Office Contact: _____

Phone Number: _____ Fax Number: _____

***Special Requirements: _____

Please email Distribution@AltruVision.org -OR- fax the completed form to 215-563-6603 at least one week prior to surgery.
Please call 215-587-9755 to confirm receipt, to ensure the surgery is noted on our schedule.