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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______/__________

**DOB is required when registering*

Surgical Facility No. 1:

Surgical Facility Name____________________

Delivery Address____________________

City____________________ State________ Zip__________

Phone______/__________Ext_______ Fax______/__________

Contact Name____________________ Email:____________________

Phone______/__________ 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:____________________

Phone:______/__________ 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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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 Specifications

Amphotericin B added to preservation media for:

☐ PKP ☐ DSAEK ☐ DMEK ☐ ALL ☐ NONE

DSAEK

Thickness Range:

☐ Ultrathin 40-70 µm* ☐ Ultrathin 71-99 µm ☐ Traditional 100+ µm

Target Thickness ________________

Target Thickness Processing capabilities are ± 25 µm of requested target.

DSAEK Orientation Marking Options:

☐ **1.** Central Dot on cap for cornea centration (non-preloaded only)
☐ **2.** “S” Stamp* on stromal side of the graft
☐ **3.** Peripheral Markings
☐ **4.** Turtle Markings
☐ **5.** No Markings

Preloaded Options *(If preloaded, select options below)*:

All preloaded grafts are stained and prepunched

☐ Weiss Glass Cannula – LWVI 2.8* ☐ DSAEK Endoglide

Graft size *(in mm)*:

☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

Scleral rim for culturing: ☐ Yes ☐ No

**Default specs for preloaded DSAEK: 40-70 µm, stain, and “S” stamp (only marking option for preloaded tissue)*

DMEK

DMEK Orientation Marking Options:

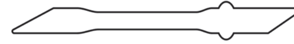
☐ **1.** “S” Stamp (Anterior View)
☐ **2.** I - II (Anterior View) Prepunched, preloaded option only
☐ **3.** None

Preloaded Options *(If preloaded, select options below)*:

All preloaded grafts are stained and prepunched

☐ Preloaded in Weiss Glass Cannula – LWVI 1.6

☐ Preloaded in Weiss Glass Cannula – Endo-In DMEK



☐ Preloaded in Weiss Glass Cannula – STRAIKO

☐ Preloaded in DMEK EndoGlide

Graft size *(in mm)*:

☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

Scleral rim for culturing: ☐ Yes ☐ No

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Surgeon Name______________________________

Surgical Facility No. 3:

Surgical Facility Name______________________________

Delivery Address______________________________

City______________________ State__________ Zip__________

Phone_____/__________Ext_______ Fax_____/__________

Contact Name______________________ Email:______________________

Phone:_____/__________ 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:______________________

Phone:_____/__________ 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:______________________

Phone:_____/__________ PO Required? ☐ Yes ☐ No Delivery Hours_______—_______

Billing Address *(if different than Delivery)*______________________________

City______________________ State__________ Zip__________

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