



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: _____

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.

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

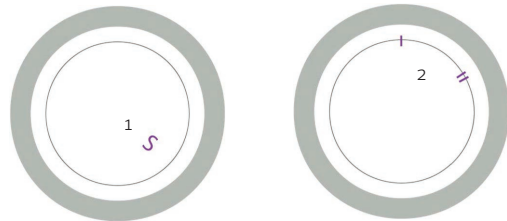
*Default specs for preloaded DSAEK: 40-70 µm, stain, and "S" stamp (only marking option for preloaded tissue)



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 – 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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