LIONS WORLD VISION INSTITUTE™

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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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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 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 (stained with Gentian Violet)**:**

Please choose one or a combination of markings.

☐ **1.** Central Dot on cap for cornea centration

☐ **2.** Peripheral Markings

☐ **3.** Turtle Markings

4. Stamp on stromal side of the graft

☐**4a.** S-stamp* ☐**4b.** F-stamp*

☐ **5.** No Markings

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

All preloaded grafts are stained and prepunched

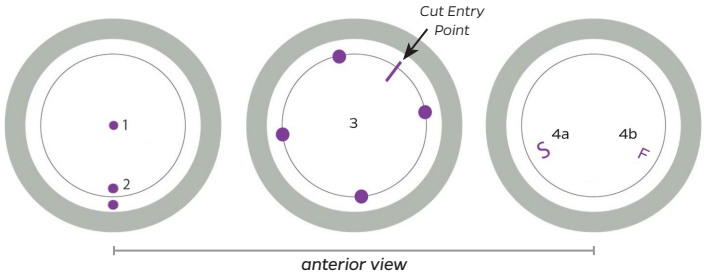
☐ Weiss Glass Cannula – LWVI 2.8* ☐ DSAEK Endoglide

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, S- & F-stamps (only marking options for preloaded grafts)*



anterior view

DMEK

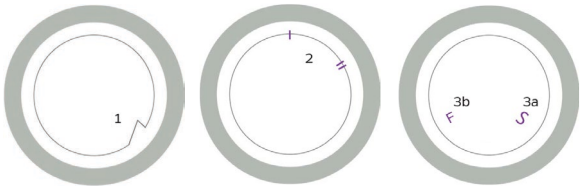
DMEK Orientation Marking Options:

☐ **1.** Shark Fin

☐ **2.** I - II marks

3. Stamps on Descemet's membrane

☐**3a.** S-stamp ☐**3b.** F-stamp



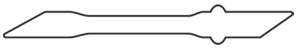
anterior view

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

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

1410 N 21st St, Tampa, FL 33605-5313 | 813.289.1200 | LWVI.org | Cornea@LWVI.org

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Multiple Facilities 3

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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