LIONS WORLD VISION INSTITUTE™

So the world can see.

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.

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

Revised 04.24.2023

LIONS WORLD VISION INSTITUTE™ | So the world can see.

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 – Ampho B: ☐ Yes ☐ No

DSAEK

Thickness Range

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

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

Non-Preloaded DSAEK Orientation Marking Options:

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

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

☐ **3.** Turtle Markings

☐ **4.** No Markings

DSAEK Preloaded Options:

Preferred preloaded device:

☐ Weiss Glass Cannula – LWVI 2.8* ☐ DSAEK Endoglide

Graft size *(in mm)*:

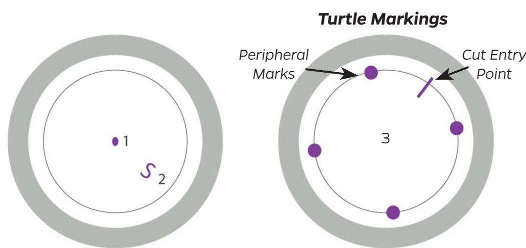
☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

Additional Options:

☐ "S" Stamp on stromal side of graft*

☐ Stain* ☐ Scleral rim for culture

**Recommended specs for preloaded DSAEK: 40-70 µm, stain, and "S" stamp*



DMEK

Prestained: ☐ Yes ☐ No

Prepunched: ☐ Yes ☐ No

Preloaded: ☐ Yes ☐ No ☐ Scleral rim for culture

If preloaded, choose preferred device below:

☐ Preloaded in Weiss Glass Cannula – LWVI 1.6

☐ Preloaded in Weiss Glass Cannula – STRAIKO

☐ Preloaded in DMEK EndoGlide

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

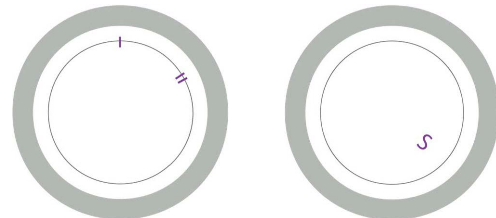
☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

DMEK Orientation Marking Options:

☐ I - II (Anterior View) Prepunched, preloaded option only

☐ "S" Stamp (Anterior View)

☐ No Markings



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

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

So the world can see.

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______________

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