



CORNEA/SCLERA TISSUE REQUEST FORM

Georgia Eye Bank, Inc

5605 Glenridge Dr. NE #250
Atlanta, GA 30342
(800) 342-9812
Fax (404) 949-0623

Information required by regulatory, accrediting and licensing agencies.

Please complete this form in its entirety. Your request will not be posted until all information is submitted. Your request will be filled on a first request, first served basis without regard to recipient age, religion, race, creed, color or national origin in accordance with the fair and equitable distribution requirement of EBAA Medical Standards K1.300. Use the same form to make requests, changes and cancellations.

Date Request Submitted: _____	Date Change/Cancellation Submitted: _____
Date/Time of Surgery: _____	New Date/Time of Surgery: _____
	Reason for Cancellation: _____

Requesting Physician's Signature (Required): _____	Purchase Order Number (As Required)*: _____
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Surgeon's Name: _____	Phone Number: () _____
Surgeon's Contact: _____	Phone Number: () _____
	Fax Number: () _____

Surgical Facility: _____

Billing Address: _____

Tissue Shipping Instructions: _____

Patient Information:	Last Name: _____	First Name: _____
<input type="checkbox"/> SSN# or <input type="checkbox"/> MR#:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
		Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Race (Check One): Caucasian African-American Hispanic Asian Native American Other

Type of Tissue Requested: <input type="checkbox"/> Cornea <input type="checkbox"/> PK Quality <input type="checkbox"/> Non-PK Quality <input type="checkbox"/> Whole Globe in moist chamber <input type="checkbox"/> Sclera in 95% Alcohol Special Request: _____ _____ _____	Indication for Surgery: Required (Check One) <input type="checkbox"/> Post-Cataract Surgery Edema <input type="checkbox"/> Keratoconus <input type="checkbox"/> Fuch's Dystrophy <input type="checkbox"/> Repeat Corneal Transplant <input type="checkbox"/> Other Degenerations or Dystrophies <input type="checkbox"/> Post-Refractive Surgery <input type="checkbox"/> Microbial Changes <input type="checkbox"/> Mechanical or Chemical Trauma <input type="checkbox"/> Congenital Opacities <input type="checkbox"/> Other Causes of Corneal Opacification or Distortion	Ocular Diagnosis: Surgical Procedure: <input type="checkbox"/> OD: _____ <input type="checkbox"/> OS: _____ <input type="checkbox"/> PK <input type="checkbox"/> LK <input type="checkbox"/> EK <input type="checkbox"/> KLAL <input type="checkbox"/> Other
		Has the patient received previous ocular surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe the date(s) and type of surgery: <input type="checkbox"/> OS: _____ <input type="checkbox"/> OD: _____

For Georgia Eye Bank Use Only:	Priority: _____	Date Posted: _____	Posted By: _____
Tissue Number Offered:	Accepted? If No, then why?	Date/Time	Surgeon Contact:
	<input type="checkbox"/> Yes <input type="checkbox"/> No		Shipping Confirmation?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
GEB Staff			

Comments: _____

* A purchase order number or the requesting surgeon's SIGNATURE is required as agreement to reimburse Georgia Eye Bank, Inc for the tissue processing fee.