Ocular Tissue for Transplant
Request Form

Georgia Eye Bank, Inc.
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(404) 949-0623 Fax
scheduling@georgiaeyebank.org

Date and Time of Request: ____/____/____ ____:_____

Contact and Phone: _____

Surgeon: _____

Surgery Location: _____ Purchase Order # (if applicable): _____

Special Tissue Shipping/Delivery Instructions: _____

Date and Time of Surgery: ____/____/____ ____:_____ Eye Involved: □OD □OS

Tissue Type Requested: □ Cornea □ Sclera □ Whole Eye

Surgery Type:
- □ Penetrating Keratoplasty (PK)
- □ Endothelial Keratoplasty (EK)
  - □ DSAEK, Should tissue be pre-cut? □ Yes □ No
  - □ DMEK, Should tissue be Patient-Ready™? □ Yes □ No
- □ Anterior Lamellar Keratoplasty (ALK or DALK)
- □ K-Pro
- □ Keratolimbal Allograft (KLAL)
- □ Glaucoma
- □ Other: _____

Special Requests Regarding Tissue/Preparation:_____

Medical Record or Social Security #: _____

First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Address: _____City:_____ State:_____ Postal Code:_____

Indication for Surgery / Pre-operative Diagnosis :

□ Post-cataract Surgery Edema
□ Repeat Corneal Transplant
□ Post-Refractive Surgery
□ Glaucoma
□ Mechanical/Chemical Trauma
□ Keratoconus
□ Microbial Changes
□ Other Degenerations or Dystrophies: _____
□ Other causes of corneal opacification or distortion: _____
□ Fuchs' Dystrophy
□ Congenital Opacities

Previous Ocular Surgeries (if yes, please include details): _____

Georgia Eye Bank Use: Request Received and Posted By: _____ *Date/Time:* _____