Ocular Tissue for Transplant
Request Form

Georgia Eye Bank, Inc.
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Atlanta, GA 30342
(800) 342-9812
(404) 949-0623 Fax
scheduling@georgiaeyebank.org

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

Contact: _____

Phone: _____ Fax: _____

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

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

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