10560 N. Ambassador Drive
Suite 210
Kansas City, MO 64153
Phone: 800-816-9263 x2
Fax: 816-255-1398
saving-sight.org

REQUEST FOR OCULAR TISSUE

The Eye Bank Association of America requires Saving Sight to obtain accurate information on all transplant recipients. Please complete the following information and return via email to clientservices@saving-sight.org or fax to 816-255-1398. Thank you.

SURGEON INFORMATION	
SURGEON NAME:	PHONE:
SURGERY INFORMATION	
SURGERY LOCATION:	CITY:
SURGERY DATE:	SURGERY TIME:

PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	
DATE OF BIRTH:	DIAGNOSIS:	
IDENTIFICATION NUMBER (SSN, MRN, ETC.):		
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	

CORNEA				LONG-TERM PRESERVED CORNEA	SCLERA
☐ PKP ☐ K-Pro ☐ KLAL ☐ TECTONIC ☐ DALK	☐ ALK ☐ DSAEK ☐ DMEK *PREPARED BY:* ☐ SAVING SIGHT ☐ SURGEON	*Additional Processing Options:* DMEK: ☐ Pre-punched ☐ Pre-loaded Graft Size (check one): ☐ 7.25 ☐ 7.5 ☐ 7.75 ☐ 8.0 ☐ 8.5	DSAEK ☐ Pre-loaded Graft Size (check one): ☐ 7.25 ☐ 7.5 ☐ 7.75 ☐ 8.0 ☐ 8.5	IN ETHYL ALCOHOL ☐ WHOLE CORNEA ☐ HALF CORNEA	☐ WHOLE ☐ HALF ☐ QUARTER

PLEASE INDICATE ANY SPECIAL TISSUE SPECIFICATIONS

Revised 02/12/2018