Donor Tissue Request Form

Name Center	
City	
Contact person	
Phone	
E-mail	

Patient card inprint / label :
Name, BSN*, gender, address, area code, place, country, date of birth, insurance company*, insurance number*

Graft eye	**OD / OS**		
Indication Cornea Tx POSTERIOR	**Indication Cornea Tx ANTERIOR**	**Concurrent disorder**	**Indication Amnion Tx**
☐ **Fuchs** ☐ **Pseudophakic bullous keratopathy** ☐ Aphakic bullous keratopathy ☐ Silicone oil KP ☐ Other, describe here:	☐ **Keratoconus** ☐ HSV à froid ☐ HSV à chaud ☐ Ulcus – See below ☐ Anterior corneal dystrophies ☐ Trauma /Chemical / thermal burns ☐ Other, describe here:	☐ Glaucoma ☐ Diabetes ☐ Down syndrome ☐ Uveitis ☐ RA & Sicca syndrome	☐ Persisting epith. defect ☐ Pterygium ☐ Symblepharon ☐ Chemical trauma ☐ Stevens Johnson ☐ Socket reconstruction ☐ Other, describe here:

☐ Re-transplantation: original diagnosis	
☐ Allograft failure: date and reason failure	

Procedure:

Posterior lamellar keratoplasty (PLK; pre-cut), depth/diameter:	☐ **Deep anterior lamellar keratoplasty (DALK)**	☐ **Random PK**	**Amnion Tx: Size:**
☐ **DSEK** _____ µm	☐ **Bowman Layer Transplantation (BL; pre-cut)** Ø _____ mm	☐ **Typed PK****	☐Ø 9.0 mm ☐3x3 cm ☐1x1 cm ☐3x4 cm ☐2x1 cm ☐4x4 cm ☐2x2 cm ☐4x5 cm ☐2x3 cm ☐5x5 cm
☐ **UT-DSEK** _____ µm		☐ **DSAEK**	
☐ **DMEK** Ø _____ mm		☐ **Other, describe here:**	

Surgeon		Planned surgery date (if known)	

The undersigned medical doctor declares that the above mentioned patient agrees to provide the above mentioned data to Amnitrans EyeBank for the purpose of his/her registration as a potential transplant recipient and to match these data against a possible donor. The undersigned furthermore declares that his/her patient has given permission to use the above mentioned data as well as the data that will become available after transplantation for allocation purposes.

Date of registration _____ Signature _____

Please send this form at least two weeks pre-op by fax to +31 10 297 4440

For further information please contact Amnitrans EyeBank Rotterdam: phone +31 10 297 4444 or mail info@amnitrans.com

* For Dutch patients only
** For typed cornea please attach HLA-typing and screening (A, B, DR)

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