Miracles In Sight

Tissue Request Form

INSTRUCTIONS: Provide the following information and return to the eye bank via fax (336-765-8803) or email (clinicalservices@miraclesinsight.org). Please notify the eye bank of any changes.

Circle one:

PK				
DSAEK	Pre-cut by eye bank?	If yes, graft thickness _____um	S-Stamp?	Other: _____
DMEK	Pre-cut by eye bank?	S-Stamp?	Other Marking? _____	
Transport Method	☐ Traditional	☐ Free floating: Graft diameter _____ mm	☐ Pre-Loaded: Graft diameter _____ mm	
IEK	Please provide parameters on separate sheet.			
LK DALK SALK	Pre-cut by eye bank?	If yes, graft thickness _____um	S-Stamp?	
Other	Circle: Tectonic	K-Pro	KLAL	Other Keratoplasty Glaucoma Shunt patch
Sclera	Circle: Quarter	Half	Whole	5x8mm

DATE OF REQUEST:	PO#:	SURGERY LOCATION:	SURGERY DATE/TIME:

SURGEON INFORMATION

Surgeon Name:			
Contact Name:			
Phone:		Fax:	

PATIENT INFORMATION

ID Number:		ID Number Type: *(Hospital, MRN, SSN, Other)*	
Patient Name: *(First Last)*			
Address:			
City, State, Zip Code: *(Country other than USA)*		Insurance Type:	
Date of Birth:		Circle: Male Female	Race:
Diagnosis:			Circle: OD OS

Enter Diagnosis from EBAA's Abbreviation List (Not ICD-10 Code)

EYE BANK USE ONLY

3900 Westpoint Boulevard, Suite F, Winston-Salem, North Carolina 27103-3903
336-765-0932 or 1-800-280-8702 |Fax: 336-765-8803| E-mail: ClinicalServices@miraclesinsight.org