

 IOWA LIONS EYE BANK	ID: LAB-DOC1-5700	Title: Tissue Request Form
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Surgeon: _____		Surgery Location: _____	
Request Date: ____/____/____		Scheduled Surgery Date/Time: ____/____/____ :____ am/pm (circle one)	
Patient's Name: _____		Age: ____	Date of Birth: ____/____/____
Address: _____		City: _____	State: ____ Zip: ____
Medical Record #: _____		Hospital History #: _____	
Race: _____		Sex: ____	Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Prof.
Ocular Diagnosis		1. _____ 2. _____	
Conventional Tissue Request		Processed Tissue Request	
Cornea: <input type="checkbox"/> DSAEK <input type="checkbox"/> PK <input type="checkbox"/> ALK <input type="checkbox"/> KLAL <input type="checkbox"/> Tectonic/K-pro <input type="checkbox"/> Other: _____		Peel: <input type="checkbox"/> DMEK <input type="checkbox"/> Pre-loaded DMEK Microkeratome: <input type="checkbox"/> DSAEK (~125 µm) <input type="checkbox"/> See Special Instructions Below	
Sclera: <input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> Whole Select Sclera Preservative: <input type="checkbox"/> 100% Ethanol <input type="checkbox"/> Glycerol		Other: <input type="checkbox"/> Glycerol Preserved Cornea <input type="checkbox"/> Other: _____	
Billing Information:		Check One: <input type="checkbox"/> Bill Surgery Location <input type="checkbox"/> Bill Other Location: _____ <input type="checkbox"/> P.O.#, if used: _____	
Special Instructions:			
Delivery Instructions:			

E-mail: OphthalmologyLEBdistribution@iowa.uiowa.edu

Phone: 319-335-4889

Fax: 319-335-4623