

<b>Donor Tissue Request Form</b>	
Name Center	
City	
Contact person	
Phone	
E-mail	

**Patient data :**  
Name, gender, date of birth, country

<b>Graft eye</b>	<b>OD / OS</b>				
<b>Indication Cornea Tx POSTERIOR</b>		<b>Indication Cornea Tx ANTERIOR</b>		<b>Concurrent disorder</b>	<b>Indication Amnion Tx</b>
<input type="checkbox"/> Fuchs <input type="checkbox"/> Pseudophakic bullous keratopathy <input type="checkbox"/> Aphakic bullous keratopathy <input type="checkbox"/> Silicone oil KP <input type="checkbox"/> Other, describe here:		<input type="checkbox"/> Keratoconus <input type="checkbox"/> HSV à froid <input type="checkbox"/> HSV à chaud <input type="checkbox"/> Ulcus – See below <input type="checkbox"/> Anterior corneal dystrophies <input type="checkbox"/> Trauma /Chemical / thermal burns <input type="checkbox"/> Other, describe here:		<input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetes <input type="checkbox"/> Down syndrome <input type="checkbox"/> Uveitis <input type="checkbox"/> RA & Sicca syndrome	<input type="checkbox"/> Persisting epith. defect <input type="checkbox"/> Pterygium <input type="checkbox"/> Symblepharon <input type="checkbox"/> Chemical trauma <input type="checkbox"/> Stevens Johnson <input type="checkbox"/> Socket reconstruction <input type="checkbox"/> Other, describe here:
<input type="checkbox"/> Re-transplantation: original diagnosis					
<input type="checkbox"/> Allograft failure: date and reason failure					
<b>Procedure:</b>					
<b>Posterior lamellar keratoplasty (PLK; pre-cut), depth/diameter:</b> <input type="checkbox"/> DSEK _____ μm <input type="checkbox"/> UT-DSEK _____ μm <input type="checkbox"/> DMEK ∅ _____ mm		<input type="checkbox"/> Deep anterior lamellar keratoplasty (DALK) <input type="checkbox"/> Bowman Layer Transplantation (BL; pre-cut) ∅ _____ mm		<input type="checkbox"/> Random PK <input type="checkbox"/> Typed PK* <input type="checkbox"/> DSAEK <input type="checkbox"/> Other, describe here:	<b>Amnion Tx: Size:</b> <input type="checkbox"/> ∅ 9.0 mm <input type="checkbox"/> 3x3 cm <input type="checkbox"/> 1x1 cm <input type="checkbox"/> 3x4 cm <input type="checkbox"/> 2x1 cm <input type="checkbox"/> 4x4 cm <input type="checkbox"/> 2x2 cm <input type="checkbox"/> 4x5 cm <input type="checkbox"/> 2x3 cm <input type="checkbox"/> 5x5 cm
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 (anonymous) clinical follow-up purposes.

Date of registration  Signature

**Please mail this form at least two weeks pre-op to [info@amnitrans.com](mailto:info@amnitrans.com)** or fax to +31 10 485 0159

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

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