Postoperative Assessment

3+ Month Postoperative Follow-up

LIONS VISION GIFT

Tissue is from an E.B.A.A. Accredited Eye Bank

DIN:
PC:

DEAR DR. ,

Please fax completed forms to 503.808.7055 or e-mail them to quality@visiongift.org. Please direct questions to 503.808.7036. Thank you. We appreciate all your help.

RECIPIENT INFORMATION

Patient Name: Date of Surgery:

Location of Surgery:

Pre-Operative Diagnosis:

Please indicate the type of surgery performed:

☐ Penetrating Keratoplasty ☐ Deep Anterior Lamellar ☐ DSAEK ☐ K-Pro
☐ Anterior Lamellar ☐ Keratolimbal Allograft ☐ DMEK ☐ Other

STATUS OF GRAFT

☐ Clear or clearing with good prognosis

For EK grafts ☐N/A

If re-bubbling was performed, how many were performed? _____ ☐ n/a

What postoperative day(s) was/were the dislocation(s) noted? _____ ☐ n/a

What postoperative day(s) was/were the re-bubbling(s) performed? _____ ☐ n/a

☐ Infection *(not intended for infections observed prior to transplant)*

Days after surgery infection was identified? _____

Do you feel the donor tissue caused the infection? ☐ Yes ☐ No

☐ Graft Failure, declared at _____ months or _____ weeks, likely due to:

- ☐ Surgical Manipulation
- ☐ Recipient Pre-existing Condition
- ☐ Recipient Rejection
- ☐ Non-Compliance
- ☐ Other non-tissue related event occurring postoperatively (e.g. trauma)
- ☐ Donor tissue

Date of regraft: _____ n/a ☐

☐ Patient Lost to Follow-Up, no known issues with tissue

PRE-OPERATIVE CULTURE RESULTS *(please attach copies of culture reports)*

☐ No cultures were performed of donor tissue.

☐ Donor corneoscleral rim cultured
- ☐ Results were negative for growth
- ☐ Positive growth results

☐ Media cultured
- ☐ Results were negative for growth
- ☐ Positive growth results

Please list the organism identified. _____

Comments

_____

_____

_____ _____

Physician's Signature Date signed

for LVG use:

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