LIONS VISION GIFT

SURGERY TYPE

DSAEK – Eye bank prepared	EK – Surgeon dissection	DMEK – Eye bank prepared
PKP	ALKP	DALK
IEK – Parameters:	K-pro	KLAL

Please enter special instructions here:

Date of request:

PATIENT INFORMATION

VisionGift is required to obtain certain information about the patient who will receive the cornea you are requesting. Please complete the information below completely. Please fill blank sections with 'N/A' when appropriate. Thank you for your cooperation.

Surgeon Name:

Surgery Center/Place of surgery:

Surgery date/time:

PO# (if applicable):

City/State:

Contact number:

Fax number:

Patient Name:

Preoperative Diagnosis (NOT ICD-9 code):

Address:

Patient ID# *(SSN, MRN, etc):*

DOB or Age:

RETURN INFORMATION

If surgery is canceled after shipment of tissue, tissue will not be accepted for return without first notifying LVG. Returned grafts must have storage conditions verified. Payment of all shipping charges incurred for shipment to and from the consignee is the responsibility of the returning facility. Restocking fees are determined on a case by case basis as determined by Lions VisionGift.

OFFICE PHONE:
503.808.7010

FAX COMPLETED FORM TO:
800.798.9040 or 503.808.7011

EMAIL COMPLETED FORM TO:
distribution@visiongift.org