

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

## Distribution

### Surgeon Feedback Report

Please use this form as a Customer Service tool and complete it only as needed. If there is missing recipient information, please complete and return to us.

The eye bank will pursue 3-6 month postoperative information separately.

#### RECIPIENT INFORMATION

Patient Name: \_\_\_\_\_ Surgeon: \_\_\_\_\_  
Age / Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
Patient ID# \_\_\_\_\_ Surgery Site: \_\_\_\_\_  
Pre-Op Diag. \_\_\_\_\_ Surgery Type: \_\_\_\_\_

#### SERVICE COMPLAINT OR SUGGESTIONS

Please tell us about any problems you've had with the service you received. You can also use this area to make suggestions.

- Tissue arrived late. *(comments, if any)*
- Tissue was not as described in offer. *(please explain)*
- Other:

#### ADVERSE REACTION OBSERVED

Please complete this section if you observed an adverse reaction immediately after surgery. Note this is not intended for non-attached grafts from EK procedures unless a regrant is necessary. The eye bank will pursue 3-6 month postoperative information separately.

Indicate type of Adverse Reaction observed:

- Graft Failure  
 Infectious keratitis  
 Endophthalmitis  
 Other (e.g. systemic viral infection)

Indicate what cultures were performed:

- Recipient cultures  
 Donor tissue cultures  
 Tissue media cultures  
 No cultures performed

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### WHO SHOULD WE CONTACT REGARDING THIS ISSUE?

Name: \_\_\_\_\_  
Role / Position: \_\_\_\_\_  
Contact Info: \_\_\_\_\_

#### PLEASE RETURN TO:

Lions VisionGift Quality Assurance Department  
email: quality@visiongift.org  
fax: 503.808.7055  
phone: 503.808.7026

FOR LVG USE: