REQUEST FORM:
FRESH CORNEAL TISSUE

KeraLink International

5520 Research Park Drive | Suite 400
Baltimore, MD 21228
Phone 800-858-2020 | Fax 443-773-3734

CONTACT INFORMATION

SURGEON _____

SURGICAL FACILITY _____

Facility Address _____

City _____ State _____ Zip _____

REQUESTOR'S NAME _____

REQUESTOR'S PHONE _____

SHIPPING INFORMATION

SURGERY DATE _____

SURGERY TIME _____

PURCHASE ORDER REQUIRED? ○ Yes ○ No

IF "YES," PROVIDE _____

PATIENT INFORMATION

PATIENT NAME _____

MEDICAL RECORD NUMBER _____ AGE _____

DIAGNOSIS _____

SURGERY DETAILS

SURGERY TYPE (Select Only One):

○ PKP ○ DALK/ALK
○ DSAEK/DSEK ○ K-PRO
○ DMEK ○ KLA

REQUESTING THAT TISSUE BE PRE-CUT?

○ Yes ○ No

USE PREFERENCES IN SURGEON'S PROFILE?

○ Yes ○ No

FOR DMEK SURGERY TYPES ONLY

REQUESTING KERALINK INFUSION SLEEVE?

○ Yes ○ No

If "Yes" to above, please verify that the facility will have the following instruments at least 48 hours in advance of surgery date provided above (**purchased separately**)**:

KeraLink tissue grasping micro forceps (Reusable):

○ Already purchased ○ Will obtain 48 hrs. before surgery

REQUESTING PRE-LOADED IN ENDOGLIDE™?

○ Yes ○ No

INSTRUCTIONS

1. Please e-mail this request to tissue@keralink.org or fax it to 443-773-3734.
2. After receiving and processing your request, a request number will be added below and sent to you via fax or e-mail.

   If request number should be sent via fax, please include return fax number: _____

FOR INTERNAL USE

To be filled out by KeraLink International and returned as confirmation that we have received and processed your request:

REQUEST NUMBER: _____

Please retain this request number for processing purposes.

Please complete and return to tissue@keralink.org.