REQUEST FORM:
VISIONGRAFT® & STERILE SCLERA

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 NUMBER _____

SHIPPING INFORMATION

TODAY'S DATE _____

PURCHASE ORDER REQUIRED? ○ Yes ○ No

IF YES, PLEASE PROVIDE*: _____

PREFERRED SHIPMENT METHOD**:
- ○ FedEx Two-Day Ground
- ○ FedEx Priority Overnight Shipping
- ○ FedEx First Overnight Shipping (Not Available for All Zip Codes)

REQUESTED DELIVERY DATE _____

*Purchase order required for shipping
**Shipping fees apply

TISSUE REQUESTED

Qty.	Code	Description	Shape
	C0302AL-90	Split Thickness Third Moon (9.0mm)	
	C0301AL-90	Split Thickness Half Moon (9.0mm)	
	C0300AL-90	Split Thickness Whole Moon (9.0mm)	
	C0100AL	Full Thickness Whole Moon Without Rim	
	C0101AL	Full Thickness Whole Moon With Rim	
	C0400AL-85	K-Pro Ring 8.5mm, 3.0mm Center	
	C0400AL-90	K-Pro Ring 9.0mm, 3.0mm Center	
	S0500SI-11	Scleral Patch (1.0cm x 1.0cm)	
	S0500SI-77	Scleral Patch (7.0mm x 7.0mm)	

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.