**WESTERN TEXAS LIONS EYE BANK ALLIANCE**
**P.O. BOX 2911**
**SAN ANGELO, TX 76902**
**PHONE: 325-653-8666 FAX: 325-655-2847**
**866-226-7632 (Toll Free)**

# ***TISSUE REQUEST***

Type of tissue requested: ☐ **Cornea** ☐ **Sclera:** ☐ Whole Globe ☐ 1/2 Globe ☐ 1/4 Globe

Date of Request: ______________________________

Date Tissue needed: ______________ Time: ______________
(Date of surgery) (Time of surgery)

## PATIENT INFORMATION

Name: ______________________________ Age: ________ Date of Birth: ______________

Sex: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Hispanic ☐ African-American ☐ Asian ☐ Native American Other: ______________

Address: ______________________________ City ______________ St Zip ______

I.D. # ______________________ Type of I.D.: ______________________
(Social Security, Driver's License, Medical Record, etc.)

## SURGICAL INFORMATION:

Name of Surgeon: ______________________________ Date of Surgery: ______________

Address: ______________________ City: ______________ St: _____ Zip: __________

Phone: ______________________ Contact Person: ______________________

Facility surgery to take place: ______________________________

**Primary Diagnosis:** ______________________________

**Secondary Diagnosis:** ______________________________

Eye requiring surgery: ☐ OD ☐ OS

Previous keratoplasties: ☐ Yes ☐ No If yes, how many? ______________

Special Requirements for donor tissue: ______________________________

______________________________________________________________

Rev. 02/06/03