CALIFORNIA TRANSPLANT

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EYE BANK ASSOCIATION of AMERICA
MEMBER EYE BANK

Corneal Transplant Waiting List

PATIENT NAME: _____ SCHEDULED SURGERY DATE: _____ TIME: _____

DATE OF BIRTH: _____ AGE: _____ SSN OR M.R. NUMBER: _____

PATIENT ADDRESS: _____

CITY, STATE, ZIP: _____

PRE-OPERATIVE DIAGNOSIS:

-CHOOSE THE APPROPRIATE PATIENT DIAGNOSIS FOR THE PLANNED SURGERY.-

PRE-OPERATIVE DIAGNOSIS FOR PENETRATING KERATOPLASTY:

☐ POST-CATARACT SURGERY EDEMA ☐ KERATOCONUS ☐ FUCHS' DYSTROPHY
☐ REPEAT CORNEAL TRANSPLANT ☐ OTHER DEGENERATIONS OR DYSTROPHIES ☐ POST-REFRACTIVE SURGERY
☐ MICROBIAL CHANGES ☐ MECHANICAL OR CHEMICAL TRAUMA ☐ CONGENITAL OPACITIES
☐ OTHER CAUSES OF CORNEAL OPACITIES

PRE-OPERATIVE DIAGNOSIS FOR ANTERIOR KERATOPLASTY:

☐ ULCERATIVE KERATITIS OR PERFORATION ☐ POST-KERATECTOMY ☐ PTERYGIUM
☐ REIS BUCKLERS DYSTROPHY ☐ CORNEAL DEGENERATION ☐ KERATOCONUS
☐ TRAUMA ☐ UNSPECIFIED ANTERIOR STROMAL SCARRING

PRE-OPERATIVE DIAGNOSIS FOR ENDOTHELIAL KERATOPLASTY:

☐ POST-CATARACT SURGERY EDEMA ☐ FUCH'S DYSTROPHY ☐ OTHER CAUSES OF CORNEAL OPACIFICATION

PLANNED SURGERY (CHECK ONE):

☐ **PENETRATING KERATOPLASTY** (PKP)
☐ **DSAEK PRECUT:** CAP SIZE/OTHER: _____
STROMA MARKED YES OR NO
☐ **DSAEK UNCUT:** SPECIFICATIONS REQUEST:_____
☐ **(LK) LAMELLAR KERATOPLASTY:** ☐ WHOLE EYE OR ☐ CORNEA
☐ **SCLERA:** WHOLE OR OTHER? _____
☐ **AMNIOTIC MEMBRANE:** SIZE? _____
☐ **OTHER:** _____

LOCATION OF SURGERY: _____

CITY, STATE: _____

P.O. NUMBER: _____

TRANSPLANTING SURGEON: _____

SURGEON EMAIL: _____ CELL PHONE NUMBER: _____

CONTACT PERSON TO ACCEPT CORNEA OFFERS: _____

EMAIL: _____

PHONE NUMBER: _____ FAX NUMBER: _____