



CORNEA REQUEST FORM

www.etb-bislife.org
 e-mail: cornea@etb-bislife.org
 tel: +31 71 408 3971
 fax: +31 251 226 808

Registration number: Registration date:

CENTRE DETAILS									
Applying centre					Telephone No.				
City / Country					Fax No.				
Ophthalmologist					Contact to				
E-mail									
PATIENT DETAILS									
Surname					Patient known to ETB-BISLIFE	Yes / No			
Prefix					Date of birth				
Initials/First name					Gender	Male / Female			
TYPE OF CORNEA									
Regular	<input type="checkbox"/> PKP Typed* (see next column) <input type="checkbox"/> PKP Random <input type="checkbox"/> Emergency: PLEASE CALL CORNEA DEPARTMENT				*In case of a typed cornea please do not forget to attach the HLA-typing and screening (when available). A, B and DR-typing are required.				
Lamellar	<input type="checkbox"/> ALKP (Anterior) <input type="checkbox"/> DALK <input type="checkbox"/> PLKP (Posterior) <input type="checkbox"/> DMEK <input type="checkbox"/> DSAEK								
This Txp.	<input type="checkbox"/> OD / <input type="checkbox"/> OS				Number of prev. Txps.	<input type="checkbox"/> OD / <input type="checkbox"/> OS			
Deep vascularization	<input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> less than 3 quadrants / <input type="checkbox"/> more or equal to 3 quadrants							
Number of allowed mismatches	<input type="checkbox"/> 0 / <input type="checkbox"/> 1 / <input type="checkbox"/> 2 / <input type="checkbox"/> 3				Is part of the scleral rim going to be used? <input type="checkbox"/> Yes / <input type="checkbox"/> No				
MAIN REASON FOR TRANSPLANTATION									
<input type="checkbox"/> Infection debulking					<input type="checkbox"/> Pain reduction				
<input type="checkbox"/> Improve vision					<input type="checkbox"/> Tectonic				
<input type="checkbox"/> Improve vision and reduce pain					<input type="checkbox"/> Other, explain				
.....									
OD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BCVA	LP -	LP +	HM (1/300-3/300)	Near blindness (1/60-2/60)	Severe impairment (0.05-0.1)	Moderate impairment (0.16-0.25)	Mild impairment (0.3-0.4)	Acceptable impairment (0.5-0.7)	No impairment (0.8-2.0)
OS			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIAGNOSIS									
<input type="checkbox"/> Fuchs endothelial dystrophy <input type="checkbox"/> Graft failure* (also fill in next column) <input type="checkbox"/> Other corneal dystrophies (except Fuchs) <input type="checkbox"/> Bullous keratopathy/sec endothelial dysfunction <input type="checkbox"/> Infectious keratitis <input type="checkbox"/> Keratectasia <input type="checkbox"/> Trauma <input type="checkbox"/> Other, explain:					*Reason graft failure: <input type="checkbox"/> Primary graft failure <input type="checkbox"/> Irreversible rejection <input type="checkbox"/> Endothelial decompensation <input type="checkbox"/> Infection <input type="checkbox"/> Recurrent original disease <input type="checkbox"/> Astigmatism <input type="checkbox"/> Other, explain:				
(Impending) perforation: <input type="checkbox"/> Yes / <input type="checkbox"/> No					Remarks:				
<p>• Please return this completed form to ETB-BISLIFE, Cornea Department, using the e-mail or fax number indicated above and make a copy for your own administration.</p>									
<p>The undersigned (Medical Doctor) declares that the patient mentioned above agrees to provide the requested data to ETB-BISLIFE for the purpose of registration as a possible graft recipient and to match these data against the data of available grafts. Furthermore, the undersigned declares that the patient has given permission for use of transplantation data, as far as necessary to optimize the mediation services of ETB-BISLIFE.</p>									
Date					Signed				