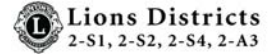




# Gratis Tissue Request



Please print all information

Date of Request: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Residence in Lions Eye Bank of Texas Service Area YES NO Phone: \_\_\_\_\_

Pre-Operative Diagnosis: \_\_\_\_\_ OD OS

Post-Operative Prognosis: \_\_\_\_\_ OD OS

Does the patient have health insurance? \_\_\_\_\_ Does the patient have Medicare/Medicaid? \_\_\_\_\_

Financial reason the patient needs "gratis" tissue

## Visual Acuity

Unaided Visual Acuity: OD \_\_\_\_\_ OS \_\_\_\_\_ Both \_\_\_\_\_

Visual Acuity with Prescription OD \_\_\_\_\_ OS \_\_\_\_\_ Both \_\_\_\_\_

## Tissue Request

Cornea for Penetrating Keratoplasty (PKP) Cornea for Endothelial Keratoplasty (EK)

**In order to be eligible for a gratis tissue the surgeon and surgery center must waive or reduce fees by 100%**

Surgeon's Fees reduced by 100% YES NO

Surgery Center's Fees reduced by 100% YES NO

Name of Individual at Surgery Center agreeing to fee reduction: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## SURGICAL INFORMATION

Surgeon Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Surgery Site: \_\_\_\_\_ City, State: \_\_\_\_\_

Surgeon Residence in Lions Eye Bank of Texas Service Area YES NO

Surgeon agrees not to seek additional payment from the patient: YES NO

Surgery center agrees not to seek additional payment from the patient: YES NO

*If funding is requested from more than one organization, both the surgeon and the surgery center must agree not to seek payment from the patient for any fees that exceed the amount of funding received from a non-profit or charitable organization.*

Is another organization providing funding? YES NO

Organization providing funding: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

This written request must be submitted one week prior to the scheduled surgery date. The Lions Eye Bank of Texas Board of Trustees Gratis Tissue Committee must review and approve the request prior to the tissue shipment and date of surgery.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please fax completed form, along with the LEBT Tissue Request to (713)798-6864 or scan and email to [judyg@bcm.edu](mailto:judyg@bcm.edu).*