



CORNEA RECIPIENT INFORMATION FORM

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 | Sex | Male / Female |
| Address | Country | |

TYPE OF CORNEA

| | | |
|-----------------|---|--|
| Regular | <input type="checkbox"/> PKP Random <input type="checkbox"/> PKP Typed* <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) (0 DALK) <input type="checkbox"/> PLKP (Posterior) | |
| This Txp. | <input type="checkbox"/> OD / <input type="checkbox"/> OS | Number of prev. Txps. OD ... / OS ... |
| Vascularisation | <input type="checkbox"/> No | <input type="checkbox"/> Yes; 0 1 quadrant, 0 2 quadrants, 0 3 quadrants or 0 4 quadrants |
| Graft failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

DIAGNOSIS

| | | |
|---|--|---|
| <input type="checkbox"/> Acanthamoebic keratitis <input type="checkbox"/> Aniridia <input type="checkbox"/> Aphakic bullous keratopathy <input type="checkbox"/> Bacterial keratitis, impending perforation <input type="checkbox"/> Bacterial keratitis, scar <input type="checkbox"/> Bacterial perforation, treatment-resistant <input type="checkbox"/> Candida keratitis <input type="checkbox"/> Chemical burn <input type="checkbox"/> Congenital hereditary endothelial dystrophy | <input type="checkbox"/> Corneal dystrophy, Groenow <input type="checkbox"/> Corneal dystrophy, Lattice <input type="checkbox"/> Corneal dystrophy, macular <input type="checkbox"/> Corneal dystrophy, other <input type="checkbox"/> Corneal dystrophy, Reiss-Buckler <input type="checkbox"/> Fuchs endothelial dystrophy <input type="checkbox"/> Fungal keratitis <input type="checkbox"/> Herpes simplex keratopathy, inactive <input type="checkbox"/> Herpes zoster keratopathy <input type="checkbox"/> HSV keratitis, impending perforation | <input type="checkbox"/> ICE syndrome <input type="checkbox"/> Keratoconus, no previous hydrops <input type="checkbox"/> Keratoconus, previous hydrops <input type="checkbox"/> Peters anomaly <input type="checkbox"/> Pseudophakic bullous keratopathy <input type="checkbox"/> Pterygium <input type="checkbox"/> Scropulotic keratitis, lues <input type="checkbox"/> Scropulotic keratitis, tbc <input type="checkbox"/> Stromal opacification, unspecified <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Other, explain: | | |
| Urgency <input type="checkbox"/> T (transplantable) <input type="checkbox"/> LWU (long waiting urg) <input type="checkbox"/> RI (risk) <input type="checkbox"/> HR (high risk) <input type="checkbox"/> HU (emergency) | | |

| | | |
|---|--------------------|----------|
| Urgency (see www.etb-bislife.org for cornea allocation criteria) | Date of operation: | Remarks: |
|---|--------------------|----------|

- Please return this completed form to ETB-BISLIFE, Cornea Department using the email or fax number mentioned above.
- Please make a copy for your own administration.

The undersigned medical doctor declares that the patient mentioned above agrees to provide the Cornea Department with the data mentioned above for the purpose of his/her registration as a possible transplant recipient and to match these data against the data of a possible donor. The undersigned furthermore declares that his/her patient has given permission to use the data mentioned above as well as the data that will become available after transplantation, as far as these are required to optimize the sharing programme of the Cornea Department.

| | |
|------|--------|
| Date | Signed |
|------|--------|