SURGEON **PROFILE**

Surgeon name:_____

Name of practice:_____

Street address:_____

City, State, Zip:_____

Email:_____

Office telephone:_____

Office fax number:_____

Cell phone:_____

Home phone:_____

Pager:_____

Name of medical school attended:_____
(Please attach a copy of your medical license)

Year and degree granted:_____

Are you Board Certified? O Yes O No

Fellowship: O Yes O No Institution: _____

Specialty:_____

List hospitals/surgery centers where you currently perform surgery:

_____

_____

_____

_____

*Revised August 1, 2017

INVOICE INFORMATION SHEET

Name of hospital/surgery center for billing:_____

Billing address:_____

Shipping address (if different):_____

City, State, Zip:_____

Telephone:_____

Fax:_____

Facility hours:_____

Delivery instructions:_____

Does this facility require a Purchase Order Number for payment of tissue received?

○ No ○ Yes - please check all applicable boxes below:

- ❒ Standing PO Number:_____ Expires:_____
- ❒ Individual PO Number:_____
- ❒ PO Number required prior to receipt of tissue

Hospital/surgery center accounts payable contact:_____

Telephone:_____ Email:_____

Hospital/surgery center purchasing dept. contact:_____

Telephone:_____ Email:_____

Hospital/surgery center operating room contact:_____

Telephone:_____ Email:_____

Questions regarding billing? Please contact our Finance Department at (734) 887-2309.
Questions regarding shipping? Please contact our Tissue Placement Department at (866) 900-8119.

**Revised August 1, 2017*

TISSUE STANDARDS

Surgeon: _____ **Office contact:**_____

Preferred contact: Email: _____ Fax: _____ Phone: _____

Tissue provided by Eversight is guaranteed to meet the tissue specification standards listed below, established by Eversight's Medical Advisory Committee, in accordance with EBAA Guidelines.

Elective PK/EK Standards

Endothelial cell count:
PK procedures: 2,000 or greater*
EK procedures: 2,300 or greater*
Preference:_____

Death to procurement interval: Less than 24 hours (Eversight average: 13 hours)
Preference:_____

Death to surgery interval: 14 days (Eversight average: 6 days)
Preference:_____

PKP/Full thickness tissue marking options:

- ❒ Epithelium centration dot
- ❒ Trephine marking

DMEK Preparation Standards

- ❒ **Standard preparation:** 9.5mm, peripheral hinge location and "S" stamp marking
- ❒ **Punched to size**

  Graft trephination options
  ❑ 7.25mm ❑ 7.5mm
  ❑ 7.75mm ❑ 8.0mm

- ❒ **Pre-loaded DMEK**

  Graft trephination options
  ❑ 7.25mm ❑ 7.5mm
  ❑ 7.75mm ❑ 8.0mm

  Graft is loaded and shipped in a Straiko Modified Jones Tube

DSAEK Preparation Standards

- ❒ **Standard:** 90-135µ post-cut thickness
  Preference:_____
- ❒ **Ultrathin:** 40-90µ post-cut thickness
  Preference:_____

Markings: Peripheral alignment mark
Optional markings:

- ❒ "S" Stromal stamp
- ❒ 9mm Trephine marking
- ❒ Epithelium centration dot

- ❒ **Pre-loaded DSAEK Preparation**

  Post-cut thickness: 70-135µ
  Preference:_____

  Optional marking: "S" Stromal stamp
  Graft size options:
  ❑ 7.5mm ❑ 8.0mm ❑ 8.5mm

Tissue culturing

All pre-loaded tissues include a free-floating 5.0mm rim segment in the vial for culturing needs.

Alternative preparation options

Eversight will accommodate tissue preparation options different from our standards. Contact Tissue Placement to discuss your preferences.

**Endothelial cell count for emergency tissue requests may vary based on tissue availability.*

TRACKING METHOD AGREEMENT

In compliance with FDA Final Rule 21CFR Part 1271, Current Good Tissue Practice for Human Cell, Tissue and Cellular and Tissue-Based Product Establishments, Inspection and Enforcement, I have been informed of the requirements of §1271.290, Tracking.

I have received a copy of this section as well as the Eversight policy and procedure for recipient information tracking (M1.511, Recipient Information Tracking Procedure).

I agree to participate in Eversight's tracking methods outlined in the above policy and procedure and will take all necessary steps to ensure compliance with these requirements.

Name (please print):_____

Signature:_____

Date:_____

*Revised January 30, 2017

SURGERY SCHEDULING INFORMATION

Please return completed form to Eversight Tissue Placement using the contact information below.

Patient name: _____

Street address: _____

City, State, Zip: _____

Telephone number: _____

Patient diagnosis: _____

Date of birth: _____ Sex: ○ Male ○ Female

Patient identifier (ex. MRN, chart #, insurance ID):_____

Surgeon: _____

Surgery location: _____

PO number (if required): _____

Surgery date: _____ Surgery time: _____

Tissue being requested:

- ❒ PKP
- ❒ DMEK (processed by eye bank)
  - ❒ Punched
  - ❒ Pre-loaded
- ❒ DMEK (processed by surgeon)
- ❒ DSAEK (processed by eye bank
  - ❒ Ultrathin
  - ❒ Pre-loaded (EndoGlide)
- ❒ DSAEK (processed by surgeon)
- ❒ ALK (processed by eye bank)
- ❒ ALK (processed by surgeon)
- ❒ DALK
- ❒ Globes for KLA Quantity:_____
- ❒ K-Pro
- ❒ LAK/IEK (processed by eye bank)
- ❒ Other (please specify):
  _____

- ❒ Sclera - whole
- ❒ Sclera - half
- ❒ Sclera - quarter
- ❒ Sclera - eighth
- ❒ 6mm disc
- ❒ Other (please specify):_____

Person completing form:_____

Contact email:_____ or FAX:_____

**Revised August 1, 2017*