Eye Bank I.D. No. : / / / Date : _____

Donor Information Form

1. Donor Name : _____ Age _____ Race _____ Sex : Male / Female
2. House Retrieval ☐ Yes ☐ No Hospital Retrieval ☐ Yes ☐ No
3. Immediate cause of Death _____
4. Physical appearance of body _____
5. Date / Hour of Death _____
6. Medical / Case History _____
7. Clinical diagnosis of removed eye RE _____
   LE _____
8. Medications _____
9. Blood drawn ☐ Yes ☐ No
   Eyes received without accompanying blood sample will not be able to be used for Transplantion purposes. If you have not been able to draw blood please explain reasons
   Reasons _____
10. Did the Physician observe the signs IV drug use or infection ? ☐ Yes ☐ No
11. Did the donor go to hospital ? ☐ Yes ☐ No If yes, length of stay _____
12. Was the donor on respirator ? ☐ Yes ☐ No If yes, how long _____
13. Did the donor receive blood products within 48 hours of death? ☐ Yes ☐ No
    If yes, Number of units _____ Last obtained - date / hour _____
14. Insitu observation _____
15. Check the following disease history : If any of the following apply, Please put tick mark in the respective box.

☐ Aids of High Risk Group	☐ Active Hepatitis	☐ Bacteremia/Septecemia
☐ Congenital Rubella	☐ Dementia	☐ Cruzfeld/Jacob diseases
☐ Encephalitis	☐ Reyes syndrome	☐ Intrinsic eye diseases
☐ Blast form leukemia	☐ Rabies	☐ Multiple leukoencephalopathy
☐ Active syphilis	☐ Conjunctivitis	☐ CNS disease of unknown etioilogy
☐ Jaundice due to non-infectious causes	☐ Sub acute sclerosing pan encephalitis	

If Hospital Retrieval, Please fill in the following :

I. Autopsy/History No. (If performed) : _____ Date of Admission : _____
II. Name of the Hospital/Institution : _____
III. Name of the Medical Examiner : _____
IV. Pathological comments concerning autopsy (If performed) _____
_____ Date _____
V. Was a hospital chart available to examine ? ☐ Yes ☐ No
VI. Was the donor refrigerated ? ☐ Yes ☐ No If yes, Date/Hour : _____
Death to refrigeration : Temperature trend :
VII. Lab test result : WBC / dates / counts :
Culture Type : Blood _____ Date _____ Growth _____
Culture Type : _____ Date _____ Growth _____
Name & Signature (of person obtained details) _____