



1. DETAILS OF THE REQUESTING HOSPITAL OR CENTRE

Implanting centre

Requesting Dr. (full name) Department

Address

Postcode Town/City

Phone no. Email

Address of delivery

Postcode Town/City

Billing centre

Phone no. Email

CIF (Tax ID code) Contact person

Policyholder/Policy no.

Authorization

Order no./Purchase order

2. RECIPIENT DETAILS

Full name Medical history no.

Age CIP/ID card Informed consent Yes No

Urgent request Yes No Reason

3. INTERVENTION

Date Time Place/Operating theatre

4. INDICATION FOR IMPLANT

Conjunctival resection Inflammatory process Other reasons (specify)
 Corneal ulceration Epithelial defect

5. TISSUE SPECIFICATIONS

BT7013 Frozen amniotic membrane (2.5 cm) **BT7025** Freeze-dried amniotic membrane (2.5 cm)
 BT7014 Frozen amniotic membrane (4.5 cm) **BT7026** Freeze-dried amniotic membrane (4.5 cm)

In accordance with the recommendations of the Servei Català de la Salut (Catalan Health Service) Corneal Transplantation Advisory Committee, Government of Catalonia Official Gazette no. 2337.

1. I hereby state that I know and meet all the stipulations of Royal Decree Law 9/2014 on the use of human tissues for transplantation.

2. I agree to provide information to the bank issuing the tissue on incidents related to the transplantation and its course.

Transplanting physician's medical licence no.

Date

Signature

The cost of transportation shall always be borne by the applicant.

