Barcelona Tissue Bank
Banc de Sang i Teixits

REQUEST FOR AMNIOTIC MEMBRANE FOR TRASPLANTATION

Sent by email to **bt@bst.cat**

1. DETAILS OF THE REQUESTING HOSPITAL OR CENTRE

Requesting Dr. (full name)
Department **Implanting centre**
Address
Postcode Town/City
Phone no. Email address
Address of delivery
Postcode Town/City
Billing centre
Phone no. Correu-e
CIF (Tax ID code) Contact person
Policyholder/Policy no.
Authorization Order no./Purchase order

2. RECIPIENT DETAILS

Full name **Medical history no.**
Age 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)
☐ **BT7014** Frozen amniotic membrane (4.5 cm)
☐ **BT7025** Freeze-dried amniotic membrane (2.5 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.

Signature

Date

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

Salut/ Banc de Sang i Teixits

Banc de Sang i Teixits
Passeig Taulat, 116
08005 Barcelona (Spain)
t (+34) 93 557 36 20
NIF Q 5856387 E

bancsang.net