



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. Email address

CIF (Tax ID code) Contact person

Policyholder/Policy no.

Authorization Order no./Purchase order

2. RECIPIENT DETAILS

Full name **Medical history no.**

Age Urgent request Yes No

Reason

3. INTERVENTION

Date Time Place/Operating theatre

4. INDICATION FOR IMPLANT

Scleral resection Inflammatory process Other reasons (specify)

Scleral ulceration Epithelial defect

5. TISSUE SPECIFICATIONS

BT7008 Whole sclera **BT7009** Half sclera **BT7010** Quarter sclera

- 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.
- 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.