SAUDI CENTER FOR ORGAN TRANSPLANTATION

المركز السعودي لزراعة الأعضاء

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Saudi Center for Organ Transplantation

استمارة تسجيل مريض زراعة القرنية

CORNEAL TRANSPLANTATION : REGISTRY FORM

Hospital Code ☐☐☐☐☐☐ **Patient No.** ☐☐☐☐☐☐ **SCOT No.** ☐☐☐☐☐☐

اسم المريض

_____ _____ _____ _____

العائلة الجد الأب رباعي

Name _____ _____ _____ _____

(First) Second Third Family

Date of filling this form: / /

1. PATIENT IDENTIFICATION

(This Section to be filled only once for every new patient)

1. Date of Birth / / 2. Sex ..... 3. Saudi I.D./Iqama No.....

4. Nationality:..... 5. Occupation:.....

6. Marital Status: Single ☐ Married ☐ Widow ☐ 7. Address: P.O. Box .....

.....

8. Blood group | A | B | AB | O |

9. Patient Tel: .....

2. PATIENT STATUS

(This Section to be filled if changes)

	Priority 1.	**Corneal perfraction [ ]** **Disease/lesion in the anterior part of the eye [ ].**
	Priority 2.	**Loss of vision due to corneal lesion with only one functioning eye.**
	Priority 3.	**Patients who are not included in any previous categories**

3. HEPATITIS SEROLOGY

Date:

HBsAg	HBsAb	HbcAb	HCVAb	HBV (Vaccine)	HIV
				Yes / No	

NAME OF DOCTOR

SIGNATURE **Date:**

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