

# Operation Form 2024 Swedish Corneal Transplant Register

## Identity

**Social security number\*** (YYYYMMDD-XXXX)  
(For non-swedish clinics: fill in the date of birth, only\*)

**Operation date\*** (YYYY-MM-DD)

## Patient

**Operated eye\***  Right  Left

**Previous graft in fellow eye\***  Yes  No

**Gender\***  Female  Male

## Preop Status

**Indication\*** (choose one alternative)

- Primary endothelial failure  Trauma  
 Secondary endothelial failure  Corneal ulceration  
 Regraft  HSV infection  
 Keratoconus  Other, pls specify:  
 Scar after non-herpetic infection  
 Stromal dystrophy

### If Regraft, specify

If regraft, check that the follow up for the previous graft has been completed, even if less than two years since the original graft.

**Number of previous grafts in this eye** (1-9)

**Original indication** (choose one alternative)

- Primary endothelial failure  Trauma  
 Secondary endothelial failure  Corneal ulceration  
 Keratoconus  HSV infection  
 Stromal dystrophy  Other, pls specify:  
 Scar after non-herpetic infection

**Operation date** (YYYY-MM-DD)

**Clinic:**

**Primary reason for transplant\*** (choose one alternative)

- Improve vision  Pain  
 Tectonic  Cosmetic

**Lens\*** (choose one alternative)

- Phakic  Pseudophakic  Aphakic

**Risk factors for graft failure\***  Yes  No

If "Yes", please specify (multiple choices are possible):

- Inflammation  Vascularisation  
 Medically controlled glaucoma  
 Previous surgery for glaucoma  
 AC IOL  Loose zonules/IOL  
 Aphakia  Other, please specify:

**Operated eye\***

- A  P  P+L  HM  CF  
 0,1  0,2  0,3  0,4  0,5  
 0,6  0,7  0,8  0,9  1,0  
 1,1  1,2

**Fellow eye\***

- Unable to measure  
 A  P  P+L  HM  CF  
 0,1  0,2  0,3  0,4  0,5  
 0,6  0,7  0,8  0,9  1,0  
 1,1  1,2

## Operation

**Date listed for operation\*** (YYYY-MM-DD)

**Operation type\***

- DSAEK  DMEK  PKP  
 SALK  DALK  
 Other, please specify:

**Other surgical procedures\***

- None  Cataract extraction + IOL  
 Other, please specify:

**Surgical complications\***  Yes  No

If "Yes", please specify:

**Eye bank\***

- Göteborg  Örebro  Lund  
 Stockholm  Aarhus  Tissue Banks International  
 Linköping  Umeå  Trondheim  
 Other, please specify:

**Donor gender\***  Female  Male

**Donor age\***

**Endothelial cell density:\***   NR  
(1000-3500 cells)