Fairfax EggBank
The Trusted Choice for Donor Eggs

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CLINIC: _____ **PHYSICIAN:** _____

Donor Number: _____ Cohort Vit Date: _____ Recipient Name: _____

OOCYTE WARMING CYCLE

Egg warming date: _____ Number of oocytes in cohort: _____
Number of oocytes warmed: _____ Number of oocytes survived: _____
Number of zygotes (2PN embryos): _____ Number of embryos cleaved: _____
Day of embryo transfer (3, 5 or 6): _____ Number of embryos frozen: _____
Freeze all: ☐ Yes ☐ No Cell stage(s) & grade(s) of embryos frozen: _____

FROZEN EMBRYO CYCLE

FET warming date: _____ Embryos survived/thawed: _____
Number of frozen embryos remaining: _____

TRANSFER INFORMATION

Number of embryos transferred: _____ Warming performed by: _____
Cell stage(s) & grade(s) of embryos transferred: _____

Were any of the below performed?

☐ Assisted Hatching ☐ Preimplantation Genetic Diagnosis/Screening (PGD/PGS) ☐ Time Lapse
(Please include Genetic Testing results in comments)

Specify **your** grading scale for our reference: _____
Highest possible embryo quality: _____ Lowest possible embryo quality: _____

PROCEDURE OUTCOME

☐ No transfer
☐ Positive pregnancy test
☐ Delivery # Male: _____ # Female: _____
☐ Negative pregnancy test
☐ Clinical pregnancy (fetal heartbeat)

Comments: _____

Are you requesting a replacement cohort on the above case: Yes ☐ No ☐
If yes, please attach semen analysis of sample used and pictures if possible.

Person filling out this form Name: _____

Email: _____ Phone: _____