Fairfax EggBank
The Trusted Choice for Donor Eggs

3015 Williams Drive, Fairfax, VA 22031
Phone: 888-352-5577 Fax: 703-991-0591
data@fairfaxeggbank.com www.fairfaxeggbank.com

**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: _____