

CLINIC _____ PHYSICIAN _____

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

OOCYTE WARMING CYCLE:

Egg Warming Date: _____
 Egg Warming Performed by: _____
 Warming Media used: _____
 Culture Media: _____
 Number of oocytes in cohort: _____
 Number of oocytes warmed: _____
 Number of oocytes survived: _____
 Number of zygotes (2PN): _____
 Number of embryos cleaved: _____
 Number of embryos transferred: _____
 Day of embryo transfer (3,5,6): _____
 Freeze all: Yes No
 Cell Stage(s) & Grade(s) of Embryos Transferred: _____
 Number of embryos frozen Day 5: _____
 Cell Stage(s)/Grade(s) of Embryos Frozen: _____
 Number of embryos frozen Day 6: _____
 Cell Stage(s)/Grade(s) of Embryos Frozen: _____

- | | |
|---|---|
| <input type="checkbox"/> No Transfer | <input type="checkbox"/> No Transfer due to PGD |
| <input type="checkbox"/> Negative Pregnancy Test | <input type="checkbox"/> Positive Pregnancy Test |
| <input type="checkbox"/> Biochemical | <input type="checkbox"/> Clinical Pregnancy (Fetal Heartbeat) |
| <input type="checkbox"/> SAB | <input type="checkbox"/> Ectopic |
| <input type="checkbox"/> Delivery # Male: _____ # Female: _____ | |

Were any of the below performed?

- Assisted Hatching
 Time Lapse
 Biopsy for PGT-A or PGT-M

(Please include Genetic Testing results in comments)

Comments:

Specify your grading scale:
 Highest Possible Embryo Quality: _____

Lowest Possible Embryo Quality: _____

Are you requesting a replacement?
 Yes No

If yes, please include a semen analysis

FROZEN EMBRYO CYCLE 1:

FET Warming Date: _____
 Embryos thawed/survived: _____
 Number of embryos transferred: _____
 Cell Stage(s) & Grade(s) of Embryos Transferred: _____

Number of Frozen Embryos Remaining: _____
 Negative Pregnancy Test
 Positive Pregnancy Test Biochemical
 Clinical Pregnancy (Fetal Heartbeat) SAB
 Delivery # Male: _____ # Female: _____

FROZEN EMBRYO CYCLE 2:

FET Warming Date: _____
 Embryos thawed/survived: _____
 Number of embryos transferred: _____
 Cell Stage(s) & Grade(s) of Embryos Transferred: _____

Number of Frozen Embryos Remaining: _____
 Negative Pregnancy Test
 Positive Pregnancy Test Biochemical
 Clinical Pregnancy (Fetal Heartbeat) SAB
 Delivery # Male: _____ # Female: _____

Person filling out this form: _____

Email: _____ Phone: _____