Specimen Complaint Form

Must be completed by Physician’s Office performing the procedure.

If the specimen(s) you received did not meet our quality standard, please fax the completed form to 703-698-3933. Your claim will be evaluated to determine if it qualifies for a credit of the specimen or a replacement of that specimen. Please allow two weeks for our quality assurance review and any possible credit processing.

Invoice #: ____________________________ Date Specimen(s) received: ____________________________
Recipient Name: ____________________________ Physician Name: ____________________________
Donor #: ____________________________ Specimen Date & Vial #: ____________________________
Specimen Type: □ ICI □ IUI □ IVF □ Frozen upon arrival?: □ yes □ no

□ ICI ART □ IUI ART

How was the specimen stored until thawed? □ dry shipper □ LN2 Storage tank (temperature of tank___) □ Other (describe): ________
Thaw Date: ____________ Thaw Procedure (check all that apply): □ Room Temp (____# min.) □ Other (describe): ____________
□ Check here if specimen arrived thawed and stop completing form. Fax this form to the above fax number.

Was the specimen washed prior to analysis? □ yes □ no
Was the specimen mixed before analysis? □ yes □ no
If yes, how? □ inverted several times □ with a pipette □ Vortex □ Other________

Was procedure performed following the post thaw preparation of the specimen? □ yes □ no
Recipient is pregnant? □ yes □ no □ too early to determine, however, expected pregnancy test date is: ____________

Post Thaw Information (Complete one form for each vial.) Use the formula below to calculate the total motile cells per vial after thaw prior to any additional processing (if applicable):

Total Concentration _____ Million/ml X Total Motility _______% / vial X Volume / vial _____ ml = Total Motile Cells _______/vial

Counting Method: □ Hemocytometer □ Makler □ MicroCell □ Cell-Vu □ Standard count
□ CASA (last date of calibration) ____________
□ Other (describe): ____________________________

Motility Method: □ room temperature slide □ RT Makler □ ~37°C slide
□ 37°C Makler □ CASA (last date of calibration) ____________
□ estimated ____________ counted ____________
□ Other (describe): ____________________________

Physician Office Staff Member who completed complaint form and verified information above:

I verify that the above information is accurate and the information listed above is reported prior to washing/further processing

Printed Name ____________________________ Date ____________ Contact Phone: ______________
Contact email: ____________________________
Comments: □ If no additional comments, check this section is N/A