

# Specimen Complaint Form

**Complaint #:**  
**Date Received:**  
**Cryobank Use Only**

**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  
 ICI ART  IUI ART  ICSI  ICSI-W  
 Frozen upon arrival?:  yes  no

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
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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