

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: f no additional comments, check this section is N/A