Fairfax Cryobank

Complaint #:
Date Received:
Cryobank Use Only

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 ☐ICI ART ☐IUI ART 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 <u>each</u> 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: ☐f no additional comments, check this section is N/A