**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 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 <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