Request For Review of Pregnancy Tissue

Physician: _____

Practice Name: _____

Contact Pers: _____

Telephone: _____

Fax: _____

Beeper: _____

email: _____

Please fill out this form completely and fax **(203-785-4477)** or mail it with authorization form to:

Harvey Kliman, MD, PhD
Dept. Obstetrics, Gynecology & Reproductive Sciences
Yale University
310 Cedar Street, FMB 225
New Haven, CT 06510

Date _____ **K2____ – _____**

Referred By (Check One): *↑Office Use Only ↑*

- ❑ **Self**
- ❑ **MD Name** _____ **MD Signature** _____

Patient Name _____

Address: _____ **Telephone:** _____

_____ **Email:** _____

Date of Birth _____ **Weight** _____ **Height**_____

G ___ P ____ SAb ____ Biochem ____ Elec Ab ____ Prem _____ Ectopic ___ Liv ____

Reproductive History: Please indicate any complications associated with any pregnancies.

Preg #	Date of Last Menstrual Period	Due Date	Date of Delivery	Gestational Age	Birth Weight (in grams)	Karyotype (if known)	Outcome
1							
2							
3							
4							
5							

Family History: Please indicate if anyone in the patient's or partner's family has had any congenital, genetic, losses or pregnancy complications: