Request For Review of Pregnancy Tissue

Physician: ______Person to receive report______

Practice Name: ______________________________

Contact Person: ______________________________

Telephone: ______________________________

Fax: ______________________________

Address: ______________________________

Email: ______________________________

Please fill out this form completely and fax **(203-785-4477)**, email **(kristin.milano@yale.edu)** 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 ______________________________ ***Yale MR#:*** ______________________

Referred By (Check One): **K2____ – ________________**

↑Office Use Only ↑

❑ **Self How did you learn about us?** ______________________________

❑ **MD Name** ______________________ **MD Signature** ______________________________

Patient Name ____

Address: ______________________________ **Telephone:** ______________________________

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______________________________ **Email:** ______________________________

Patient Date of Birth ____________________ **Weight** ________ **Height**____________

G ___ P ___ SAb ___ Biochem ___ Elec Ab ___ Prem ___ Ectopic ___ IUFD ___ Liv ___

↑For Office Use Only ↑

Reproductive History: Please list all pregnancies that you have ever had, starting with the first one.

Preg # (list all starting at first)	Date of Last Menstrual Period	Due Date	Date of Delivery	Weeks of Pregnancy at Delivery	Birth Weight (grams)	Karyotype (if known) and/or sex	Outcome: live, still, D&C, D&E, other
1							
2							
3							
4							
5							

Family History: Please indicate if anyone in the patient’s or partner’s family has had any pregnancy losses or any congenital, genetic, or other pregnancy complications (attach page if necessary):