Request For Review of Pregnancy Tissue

Current Ob, MFM, CNM: Person to receive report

Practice Name: _____

Contact Person: _____

Telephone: _____

Fax: _____

Address: _____

Email: _____

Please fill out this form completely and fax **(203-737-4397)**, 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:** _____

_____ **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):