ColumbiaDoctors

Columbia University Fertility Center 5 Columbus Circle PH Floor New York NY 10019

TRANSPORT QUESTIONNAIRE (to be completed by releasing facility)

Patient Name: _____ DOB:_____

Partner Name: _____DOB:_____

SPERM TRANSPORT **Phone:** 212-314-8825 **Fax:** 8801 **Email**: fertility-lab@cumc.columbia.edu

☐**Donor** (anonymous or directed) ☐**Client Depositor** ☐ **#vials/ straws** to be transported _____

Name and/or Number donor#: _____ **PLEASE PROVIDE ALL NOTES AND TESTING**

OOCYTE/EMBRYO TRANSPORT **Phone:** 212-314-8809 **Fax:** 8801 **Email**: fertility-lab@cumc.columbia.edu

Retrieval Date(s): _____ ☐ Insemination ☐ ICSI ☐ BOTH

Cryo Date(s):_____ Cryo Devise used: _____

Cryo method: ☐vitrification ☐slow freeze ☐other_____(provide information)

Media used: _____ If in- house, commercial alternative:_____

Stage frozen (circle one): oocytes / 2pn / day 2 / day 3 / day 5 / day 6 OTHER? _____

#of straws/ vials (circle one): _____ # of oocytes/ embryos (circle one):_____

If PGD/S which embryos will be transported, provide the #'s _____(send report)

Please include the following:

☐Thaw protocol
☐ Infectious disease testing results
☐ Embryology worksheet
☐ Donor eligibility if applicable
☐ If PGS/D? Send results and which will be transported
☐ DOH license and FDA registration certificate.

FDA STATUS (check one)**:**

- ☐ **EXEMPT –** sexually intimate partner or autologous use only
- ☐ **EXEMPT –** ELIGIBLE oocyte donor with sperm
- ☐ **EXEMPT –** ELIGIBLE sperm donor with oocyte
- ☐ **EXEMPT –** ELIGIBLE oocyte donor and ELIGIBLE sperm donor

☐ **WARNING, REACTIVE FOR: _____(advise patient of communicable risk)**

Currently stored: _____

Address: _____

Contact Name: _____ Email:_____

Phone Number: _____ Fax Number: _____

The Laboratory is FDA compliant and is not under disciplinary action at this time.

Signature of Responsible representative:_____ Date:_____