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 ______________________________ **K1**____ – ________

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	Karyotype (if known)	Outcome
1						
2						
3						
4						
5						
6						

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