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#:* _____

How did you learn about us? _____ **K2**____ – _____

↑*Office Use Only* ↑

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. Send medical records by fax **(203-737-4397)**, or email **(kristin.milano@yale.edu & harvey.kliman@yale.edu)**.