

TRANSPORT QUESTIONNAIRE (to be completed by releasing facility)

Patient Name: _____ DOB: _____

Partner Name: _____ DOB: _____

SPERM TRANSPORTPhone: 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.eduRetrieval Date(s): _____ # retrieved: _____ ☐ Insemination ☐ ICSI ☐ BOTH

Cryo Date(s): _____ Cryo Device 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:

- | | |
|---|---|
| <input type="checkbox"/> Thaw protocol | <input type="checkbox"/> Donor eligibility if applicable |
| <input type="checkbox"/> Infectious disease testing results | <input type="checkbox"/> If PGS/D? Send results and which will be transported |
| <input type="checkbox"/> Embryology worksheet | <input type="checkbox"/> 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: _____