

PREGNANCY OUTCOME

We maintain records of all outcomes – births, miscarriages, stillbirths and therapeutic abortions. This helps maintain a donor's family limit, track health information for donors, recipients and children, and provide ongoing services to families, including alerts when medical issues arise. This report concerns your most recent pregnancy with TSBC samples. If you are unsure about a question, leave it blank. We guarantee complete confidentiality. No identifying information is released. Thank you.

Recipient's full name: _____ Today's date: ____/____/____

Partner's full name (if applicable): _____ TSBC staff initials: _____

Is your partner a TSBC recipient (if applicable)? Yes No Has your partner conceived with TSBC sperm? Yes No

Has your address, email or phone changed? Yes No If yes, please include new details: _____

TSBC Donor #: _____ TSBC Pregnancy #: _____ Miscarriage or Stillbirth* at: _____ # weeks Miscarriage #: _____

*Please complete pre-natal screening questions for all miscarriages/stillbirths

Live birth: Single Twins Triplets

Date of delivery: ____/____/____ @ _____ weeks # Vials stored at clinic/MD office? _____

Pregnancy Details (circle all that apply):

Abnormal Fetus Position Bleeding Placenta Problem High Blood Pressure Gestational Diabetes

Pre-eclampsia Toxemia No Issues Other: _____

Did you have any Prenatal Screening +/-or Diagnostic Testing? No testing was done

Amniocentesis 18-20 week Ultrasound CVS (Chorionic villus sampling) Cell-free DNA blood test/NIPT (e.g. Harmony)

Serum screening/ Nuchal translucency (NT) Other: _____

Results of screening/testing? Normal Other: _____

Delivery Type:

Spontaneous Vaginal Induced Vaginal Scheduled C-section Emergency C-section

Delivery Setting:

Home Hospital Birthing Room Labor & Delivery OR Other: _____

Delivery Details:

Breech Hemorrhage Augmentation Pitocin Suction Forceps Fetal Distress Maternal Distress No Issues

Child #1: _____

First Middle Last

Sex assigned at birth: female male other: _____

Health at Birth: excellent good fair poor Weight: _____ Length: _____ APGAR Score #1: _____ #2: _____

Birth Defects/Genetic Concerns: _____

Child #2: _____

First Middle Last

Sex assigned at birth: female male other: _____

Health at Birth: excellent good fair poor Weight: _____ Length: _____ APGAR Score #1: _____ #2: _____

Birth Defects/Genetic Concerns: _____

Interested in purchasing sibling inventory (buy ASAP to guarantee availability)? Yes No Already Own Vials # Embryos stored*: _____

*Planning to donate embryos? Please contact us to check family limit & provide new family with health alerts.

INTERNAL USE ONLY

Recipient Account# _____ Data Entered: ____/____/____ Staff: _____

Congrats/Onesie/Family Services Letter sent Storage Dates Reviewed/Changed General Vials changed to Sibling
 Changes to Address/Name added to GP Changes to Address/Name added to Recipient Chart Addressed Comments/Questions