PREGNANCY OUTCOME

We require records of all births, miscarriages, stillbirths and therapeutic abortions. This helps maintain donor family limits, track health information for donors, recipients and children, and provide ongoing family services, including medical alerts. We guarantee confidentiality. No identifying information is released. Thank you.

Recipient's full name: _____ Pronouns: _____ Your birthdate : ____/____/_____

Partner's full name (if applicable): _____ Pronouns: _____

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 #: _____ Stillbirth* at: _____ # weeks Pregnancy loss#: _____

*Please complete pre-natal screening questions for all stillbirths

*If miscarriage, please instead complete Report for Pregnancy Loss

How many TSBC pregnancies have you had? *(including this one) 1 2 3 4 5 6*

Live birth: *Single Twins Triplets*

Date of delivery: ____/____/____ @ _____ weeks # Vials stored at clinic/MD office? *(Not at TSBC)* _____

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

Interested in purchasing sibling inventory (buy ASAP to guarantee availability)? *No Maybe Yes*

Pregnancy Details (circle all that apply):

Abnormal fetus position Bleeding Placenta problem High blood pressure Gestational diabetes

Pre-eclampsia Toxemia No issues Other: _____

Prenatal Screening +/or Diagnostic Testing? *No testing done Amniocentesis 18-20 wk Ultrasound Chorionic villus sampling (CVS)*

Cell-free DNA blood test/NIPT Serum screening/ Nuchal translucency (NT) Other: _____

Results of screening/testing? *Normal Other:* _____

Delivery Type:

Spontaneous vaginal Induced vaginal Scheduled C-section Unplanned 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 Epidural No Issues Other: _____

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: _____

INTERNAL USE ONLY

Recipient Account# _____ Date Received: _____/_____/_____ 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

Data Entered: _____/_____/_____ Staff: _____