origin SPERM BANK

QUALITY COMPLAINT REPORTING FORM

Date: _____ DONOR #: _____ LOT#:_____

Reporting Clinic Name: _____

Inseminating Physician: _____ Patient Name: _____

Vial Type: ☐ Unwashed ☐ Washed ☐ IVF/ICSI

Date Sample Received: _____ Condition of Shipper: ☐ Charged ☐ Thawed

(If sample arrived thawed, contact Origin immediately)

Date Sample Thawed: _____ Method of Thawing: ☐ RT ☐ 37°C For how long? _____

(Recommended thawing instructions must have been followed)

INITIAL EVALUATION
(BEFORE ANY FURTHER PROCESSING IS PERFORMED BY YOUR LAB)

Was sample mixed before evaluation? ☐ Yes ☐ No

Method used to obtain sperm count? ☐ CASA ☐ Hemocytometer ☐ MicroCell ☐ Makler ☐ Other

SAMPLE EVALUATION

Initial Sample:
Volume _____(ml) X Concentration _____(million/ml) X Motility _____(%) =

Total Motile Concentration _____per vial

Was sample washed after initial evaluation by your lab? ☐ Yes ☐ No
If yes, complete below:

Post-Wash:
Volume _____ (ml) X Post Thaw Concentration _____(million/ml) X Motility _____(%) =

Total Motile Concentration: _____

Was the unit used for insemination? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No ☐ Too early to test; expected pregnancy test date: _____

Type of assisted reproduction: ☐ ICI ☐ IUI ☐ IVF ☐ ICSI

Comments: _____

I attest to the accuracy of the above information.

_____ _____

Signature Printed Name

_____

Date

Once ALL sections are completed, you can email this form to info@originspermbank.com or fax to 416-233-9180. Please review the conditions for Origin's Quality Guarantee at: http://www.originspermbank.com/find-donor-sperm/quality-control

56 Aberfoyle Crescent, Suite 300, Toronto ON M8X 2W4
Email: info@originspermbank.com
Phone: (416)-233-1212 Fax: (416) 233-9180
Website: www.originspermbank.com