

## *Request For Review of Pregnancy Loss Slides*

Physician: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Contact Pers: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Beeper: \_\_\_\_\_  
**email:** \_\_\_\_\_

Please fill out this form completely  
 and fax (203-785-4477) or mail it  
 with authorization form to:

Harvey Kliman, MD, PhD  
 Dept. Ob/Gyn, Yale University  
 Suite 770  
 300 George Street  
 New Haven, Connecticut 06511

Date \_\_\_\_\_

K0 \_\_\_\_\_ - \_\_\_\_\_

Referred By (Check One):

↑ Office Use Only ↑

Self

MD Name

MD Signature \_\_\_\_\_

Patient Name \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_  
 Email: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

G \_\_\_ P \_\_\_ SAb \_\_\_ Biochem \_\_\_ Elec Ab \_\_\_ Prem \_\_\_ Ectopic \_\_\_ Liv \_\_\_

**Reproductive History:** Please indicate any complications associated with any pregnancies.

Preg #	Date of Last Menstrual Period	Due Date	Date of Delivery	Gestational Age	Karyotype (if known)	Outcome
1						
2						
3						
4						
5						

**Family History:** Please indicate if anyone in the patient's or partner's family has had any congenital, genetic or pregnancy complications: