IVF SYD
Fertilitetsklinik

PREGNANCY AND BIRTH REGISTRATION FORM

Name of female:_____

Female's date of birth:_____

Treatment:

☐IVF ☐Micro-insemination (ICSI) ☐Frozen/thawed eggs ☐Egg donation ☐Insemination

PREGNANCY:
Have you had a karyotype analysis made on the fetus(es):

a) Amniotic fluid sampling ☐ yes ☐ no

b) Chorionic villus biopsy ☐ yes ☐ no

If yes, was the result normal: ☐ yes ☐ no
If not, please describe:

Did the pregnancy end by miscarriage: ☐ yes ☐ no
If yes: Miscarriage before gestation week 12: ☐ yes ☐ no
Miscarriage in gestation week 12 - 20: ☐ yes ☐ no
Miscarriage in gestation week 20 -28: ☐ yes ☐ no
Ectopic pregnancy: ☐ yes ☐ no

BIRTH:
Date of birth: ___/___/___ at_____ Hospital, country:_____

☐ Boy ☐ Girl Weight:_____g Length:_____ cm

In which gestation week did you give birth:_____

☐ Natural birth ☐ Induced labour

Was the child delivered via a Caesarian section: ☐ yes ☐ no
Was the child born using suction/forceps ☐ yes ☐ no
Is the child healthy: ☐ yes ☐ no

If no, what is wrong:_____

If you gave birth to more than one (1) child, please complete a form for each child.

Thank you for your help – please send the form to the address stated below (or info@ivf-syd.dk)