ONCOFERTILITY PROGRAMS &
TESTICULAR TISSUE CRYOPRESERVATION STUDY
PATIENT SPECIMEN TRANSFER DATA

To Be Completed by the Transferring Clinic

Transferring Clinic _______________________________________Date ______________

Patient's Name ____________________________________

Patient's Identification Number (if applicable)_______________________________

PLEASE ATTACH COPIES OF PATIENT RECORDS
Were these specimens frozen via vitrification? ❑ Yes ❑ No
If vitrified, describe packaging (i.e. cryoloop, etc) _____________

Have any specimens contained in this shipment tested positive for Hepatitis, HIV, Syphilis, West Nile Virus, COVID-19 or other relevant communicable disease agent/disease?
❑ Yes* ❑ No * If yes, contact ReproTech for potentially infectious shipping arrangements.

PATIENT'S REPRODUCTIVE CELLS/TISSUE

Type: ❑ Semen ❑ Surgically Retrieved Sperm and\or Testicular Tissue ❑ Ovarian Tissue

Packaging: ❑ vials ❑ straws ❑ other: _____________

Cryopreservation Date: ________________ # of vials/straws ____________
Cryopreservation Date: ________________ # of vials/straws ____________
Cryopreservation Date: ________________ # of vials/straws ____________
Cryopreservation Date: ________________ # of vials/straws ____________

SPECIMENS ARE IDENTIFIED BY THE FOLLOWING MARKINGS:

Total # of vials/straws____ Labeling on vials/straws:____

# of canes: __________ Labeling on canes :____

PATIENT'S PLASMA

Packaging: ❑ vials ❑ straws ❑ other: ______________

Cryopreservation Date: ___________________# of vials/straws for this Cryo. Date_________
Cryopreservation Date: ___________________# of vials/straws for this Cryo. Date_________

SPECIMENS ARE IDENTIFIED BY THE FOLLOWING MARKINGS:

Total # of vials/straws_______ Labeling on vials/straws: ____

# of Canes:___________ Labeling on canes :____

Please Print:____
Authorized Staff Member Name Email Phone