institut marquès

REQUEST FOR PATIENT INFORMATION REGARDING CHROMSOMAL REARRANGEMENTS

CENTRE:	DATE OF THE VISIT:
CHROMOSOMAL REARRANGEMENT:	

PATIENT INFORMATION

Name of the female patient:	
Karyotype:	
Date of birth:	Phenotype:
Pregnancies and miscarriages:	
Name of the male patient:	
Karyotype:	
Date of birth:	Phenotype:
Pregnancies and miscarriages:	

FAMILY HISTORY of the carrier:

Relation	Karyotype	Pregnancies and/or miscarriages	Illnesses?

PREVIOUS FERTILITY TREATMENTS:

Treatment	Date	Place	Nº Eggs	Nº Fertilised	NºTransferred	Pregnancy	Outcome

OTHER RELEVANT INFORMATION: