

## Reporting a suspicion of an adverse reaction



EUROPEAN  
SPERM·BANK

Once the form below is completed, please save and return the PDF to [genetics@europeanspermbank.com](mailto:genetics@europeanspermbank.com)

### Identification of parties involved

Donor ID/Alias:

Clinic's name:

Recipient, Name/initials:

Recipient, DOB:

### Outcome of Pregnancy

Abortion Week:

Live birth

Stillborn

Child, Name/initials:

Gender of child/fetus:

Male

Female

DOB/abortion date (dd.mm.yyyy):

Malformations:

Symptoms:

Diagnosis (discovery of problem(s) - incl. dates):

### Investigations (please add results)

Genetic results: Attach original genetic test results when you return the form.

Other results:

Expected time for result: