IVF CHECKLIST - NEW YORK
FRESH CYCLE

Patient Name _____ **Account #** _____

Spouse Name _____ **Account #** _____

Required Testing Female	Date Ordered	Date Done	Results	Repeat Date	Results
Infectious deseases					
RPR (Syphilis)					
HIV 1					
HIV 2					
HTLV 1 &2					
Hep B Surf Ag					
Hep C Ab					
Routine screening					
Blood Group & RH					
Rubella					
TSH					
Prolactin					
Vitamin D					
Androgen panel & cortisol & SHBG					
CBC					
HSN					
PAP with HPV					
GC/CT Gonorrhea/Chlamydia					
Physical Exam					
Mammogram					
Fragile X					
Cystic Fibosis					
Spinal Muscular Athrophy					
Immune work-up					
Antinuclear Antibody Panel					
Antiphospolipid Antibody Panel					
Immunoglobulins IGG/IGA/AGM/IGE					
Lupus Anti-Coagulant					
Tyroid Peroxidase Antibody					
Thyrotropin Receptor Antibody					
Antithyroglobulin Antibody					
Adiponectin					
C-Reactive Protein					
Interleukin-6					
Leptin					
Selective:					
HSG					
Jewish Panel					
hemoglobin electrophoresis (afr.amer;asian;mediterenian)					
Recommended Adult Immunization as per CDC	done within recommended time		done on date		refused
OTHER:					
Required Testing Male	**Date Ordered**	**Date Done**	**Results**	**Repeat Date**	**Results**
Semen Analysis					
RPR (Syphilis)					
HIV 1					
HIV 2					
HTLV 1 &2					
Hep B Surf Ag					
Hep C Ab					
OTHER:					
Consents signed:					
cycle start registered in SART					

Physician Review Signature _____ Date _____

Coordinator Review Signature _____ Date _____

review date: 8/20/2014