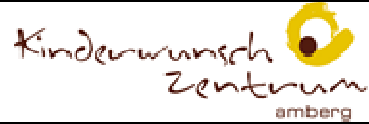
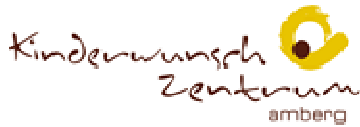


Interne Formulare

Datei:M:\Interne Formulare\Kiwu\Mappen IVF_ICSI Englisch\Rückmeldung Schwangerschaftsverlauf nach Kinderwunschbehandlung englisch Version 1.doc



Kinderwunschzentrum



Dr. med. Jürgen Krieg

Emailfabrikstr. 15
92224 Amberg
Tel: 09621 769370
Fax: 09621 9601612
e-mail: info@dr-krieg.de

Pregnancy Feedback

Please put this in your Motherpass and fill it out with the doctor after the birth or the end of the pregnancy and send it back to our office. Thank you!

Last Name _____ **First Name** _____ **Birthdate:** _____

Pregnancy through:

Insemination Puncture Cryo Date of the Transfer/Insemination _____

Abort Date of the Abort _____

EDD (due to conception): _____

Abortion Date of the abortion _____

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Single Pregnancy | amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| <input type="checkbox"/> Twin | Child 1: amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| | Child 2: amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| <input type="checkbox"/> Triplet | Child 1: amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| | Child 2: amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| | Child 3: amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |

Complications in the pregnancy with allegation of the pregnancy week

- | | | |
|--|--|--|
| <input type="checkbox"/> none | <input type="checkbox"/> unknown | <input type="checkbox"/> early contractions |
| <input type="checkbox"/> bleedings | <input type="checkbox"/> gestosis | <input type="checkbox"/> Hellp-Syndrome |
| <input type="checkbox"/> imminent preterm birth | <input type="checkbox"/> placenta praevia | <input type="checkbox"/> early placenta detachment |
| <input type="checkbox"/> early rupture o.t.membranes | <input type="checkbox"/> amniotic infection syndrome | <input type="checkbox"/> pregnancy diabetes |
| <input type="checkbox"/> intrauterine growth retardation | <input type="checkbox"/> Other _____ | |

Date of the birth _____ **Pregnancy Week** _____

Delivery of childbirth

spontaneous vaginal (forceps, force cup) C-section pelvic presentation

	Child 1	Child 2	Child 3
Gender	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl
Weight	_____	_____	_____
Size	_____	_____	_____

State of the child	<input type="checkbox"/> healthy	<input type="checkbox"/> healthy	<input type="checkbox"/> healthy
	<input type="checkbox"/> intensive care	<input type="checkbox"/> intensive care	<input type="checkbox"/> intensive care
	<input type="checkbox"/> stillbirth	<input type="checkbox"/> stillbirth	<input type="checkbox"/> stillbirth

Thank you for your cooperation! We wish you all the best! Your office team!

MVZ Gynäkologisches Zentrum Amberg-Sulzbach GmbH, (HRB 5715-AG Amberg, GF Dr. med. Jürgen Krieg),
Hauptsitz: Emailfabrikstr. 15, 92224 Amberg

Erstellt von: Schlamberger	Freigegeben von: Dr. Krieg	Geändert durch:	Version 1
Datum: 08.10.19	Datum: 08.10.19	Datum:	