Embryo Donation INTERNATIONAL Building Families

Dear Physician:

As part of the Federal oversight process of all Assisted Reproductive Technology (ART) clinics, we are obligated to obtain verification of all births resulting from our ART procedures. This verification may be accomplished with the completion of the form below.

We are depending upon you and your staff to assist us in this mandatory reporting process. **In order to facilitate this process, we thought this form could be completed at the first postpartum visit**. While we also will be asking for information from your patient, including a birth announcement and copy of the birth certificate, the current regulations require that your input be secured. Please understand that this is a Federal mandate.

We truly appreciate your assistance in fulfilling these regulatory obligations. If there are any special circumstances not covered in the form below, please include them on a separate page. As always, it is a pleasure to take care of your patients.

Please PRINT!

Patient Name:	
❒ Spontaneous Loss **did** occur (< 20 weeks)	
❒ Therapeutic Abortion **did** occur (Please append description).	
Delivery Date:	
Newborn Data	
Singleton	Sex: _____ Weight: _____ grams Length: _____ cm. If with anomalies, please append description.
Twin (Second Child)	Sex: _____ Weight: _____ grams Length: _____ cm. If with anomalies, please append description.
Triplet (Third Child)	Sex: _____ Weight: _____ grams Length: _____ cm. If with anomalies, please append description.

Physician Signature _____ Date: ___/___/___

(Please mail or fax completed form to 239-275-5914)

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