Specialists In Reproductive Medicine & Surgery, P.A.

www.DreamABaby.com • Fertility@DreamABaby.com

Excellence, Experience & Ethics



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 (legal copy or original not necessary), 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 questions 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)

Updated: 1/12/2010

 $K: \backslash Docs \backslash Forms \backslash ART \ Delivery \ Verification \ form. doc$

 $Copyright © 1999, Specialists In \ Reproductive \ Medicine \& Surgery, P.A., E-mail: \underline{Fertility@DreamABaby.com}, Web: \underline{www.DreamABaby.com}$