

# Specialists In Reproductive Medicine & Surgery, P.A.

www.DreamABaby.com • Fertility@DreamABaby.com

*Excellence, Experience & Ethics*



## Notification of Medical or Genetic Concerns By The Commissioning Couple-Intended Parent Assisted Reproductive Technologies

### Introduction:

As a courtesy to the Conventional Surrogate (CS) who donated her eggs and uterus, we ask that you notify **Specialists In Reproductive Medicine & Surgery, P.A. (SRMS)**, of any significant medical or inheritable diseases that are found in your Conventional Surrogacy offspring. The information you provide here may be of use to the CS, her relatives/offspring as well as other families she may have also assisted.

Likewise, we have also asked the CS to notify us if any of her relatives or children are found to have a new significant medical or genetic disease that could influence the future medical care of your Conventional Surrogacy offspring.

### Identifying Information:

Since you may have moved, please update your identifying information below:

Your Name(s) at time of CS:		Year of CS Procedure:
Current Name(s):		Birth Date(s):
Current Address:		
City:	State	Zip Code
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

*(Please only provide identifying information that you will allow us to use to contact you.)*

### Physician Name:

Please provide us with the physician's name that made the diagnosis. Please be sure to sign a release of information form so that we may speak to the physician. If you prefer, please have them simply send a written summary. We will not breach confidentiality issues and will not tell them of your reproductive history. We will simply need to understand the medical issues involved in the newly diagnosed genetic disease:

Notification of New Medical or Genetic Concerns By The Commissioning Couple-Intended Parent  
(cont.)

Physician Name:	Type of Physician:	Phone Number:
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**New Genetic Concerns:**

Please keep in mind that the new genetic concerns should only involve the Conventional Surrogacy offspring and not other family members:

Child's Name	Age at Diagnosis	Actual Diagnosis	Consequences of Diagnosis (Use separate paper if needed)

*Please feel free to us additional paper, if needed.*

***Please keep this form in a safe location and notify us should it become necessary.***

**Contact Us If Uncertain:**

If you are uncertain if a disease is significant or genetic (i.e., inheritable), please ask your physician or call us here at SRMS. We thank you for your assistance in keeping the CS and the staff here at SRMS informed.

_____	_____	___/___/___
Commissioning Parent's Signature	Commissioning Parent's Name (print)	Date
_____	_____	___/___/___
Additional Parent's Signature (when applicable)	Addit. Parent's Name (print) (when applicable)	Date
_____	_____	___/___/___
IVF Coordinator's Signature	IVF Coordinator's Name (print)	Date
_____	_____	___/___/___
SRMS Physician's Signature	SRMS Physician's Name (print)	Date