Request for Program for Multiples Assessment and Evaluation

DEMOGRAPHIC INFORMATION

Patient name

Date of birth | Social Security number

Patient address

E-mail

Home phone | Work phone | Cell phone

Primary obstetrician*

Physician name

Nurse/contact

Phone number | Fax number

Address

Reproductive endocrinology and infertility specialist (if applicable)

Physician name

Nurse/contact

Phone number | Fax number

Address

* If you have not designated a primary obstetrician, we are happy to help you with this process.

INSURANCE INFORMATION (Please bring your insurance card to your appointment.)

Insurance carrier | Insurance phone

Employer | Group number | Policy number

Copayment amount | Expiration date

PREGNANCY HISTORY

First pregnancy? _______ yes _______ no

If no: 1) dates of previous pregnancies ____________________

2) outcomes of previous pregnancies ____________________

Estimated date of delivery (current pregnancy) ____________________

Pre-pregnancy weight ____________________

Height ____________________

Method of conception (current pregnancy)

- ☐ Spontaneous/natural
- ☐ IVF ______ ICSI ______ Assisted hatching
- ☐ Chemical stimulation
- ☐ Donor eggs
- ☐ Donor sperm

DOCUMENTS

Please obtain the following records from your physician and fax them to us at **(713) 798-2810**. If you have a complicated medical history, please contact us for additional record requests.

- ☐ Screen results (FST, triple, quad)
- ☐ CBC
- ☐ Blood type, antibody screen
- ☐ Ultrasound report

Texas Children's Fetal Center
Program for Multiples
1-877-FetalRx (338-2579) – toll-free
(713) 798-8621 Phone
(713) 798-2810 Fax

Program for Multiples

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