

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*

Reproductive endocrinology and infertility specialist (if applicable)

Physician name _____

Nurse/contact _____

Phone number _____ Fax number _____

Address _____

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) Blood type, antibody screen
- CBC 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