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 ______________________________

Subscriber ____________ | Subscriber date of birth ____________ | 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 ______________________________

Last menstrual period ______________________________

Method of conception (current pregnancy)

☐ Spontaneous/natural ☐ Chemical stimulation

☐ IUI ________________ Date

☐ IVF _____ ICSI _______ Assisted hatching

____________ Date of transfer

____________ Number of embryos transferred

☐ 3 day embryo ☐ 5 day embryo

☐ Donor eggs ☐ Donor sperm

INSTRUCTIONS

Please obtain the following records – screen results (FST, triple, quad), CBC, blood type (antibody screen) and ultrasound report – from your physician and fax to us at **832-825-9402**. In addition, please submit your completed form via fax or e-mail. A member of our team will contact you to confirm your appointment details.

Program for Multiples

832-826-7500 Phone (Select option 2)

832-825-9402 Fax

multiples@texaschildrens.org

women.texaschildrens.org/multiples

Pavilion for Women

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