
## MEDICAL EVALUATION

***(If current patient of IRH, Parental Hope will obtain completed form. If not a current patient of IRH, your treating physician must complete this form.)***

Patient's (Applicant's) Name:_____

Patient's Partner's (Co-Applicant's) Name:_____

Length of Infertility:_____

FEMALE EVALUATION:

Medical Problems and/or Infertility Diagnosis:_____

_____

_____

_____

Surgical History:_____

_____

_____

_____

MALE EVALUATION:

Medical Problems and/or Infertility Diagnosis:_____

_____

_____

Please briefly describe the patient's likelihood of conceiving without medical intervention, with minimal medical intervention (basic therapy) and likelihood of conceiving with IVF._____

_____

_____

What is your recommendation for treatment for this patient? (Please make note of any additional treatment needs such as ICSI, PGD, etc._____

_____

_____

THIS FORM HAS BEEN COMPLETED BY: _____(please print)

DATE:_____ _____ (signature)