THE OPERATION BABY FOUNDATION
Medical Infertility Diagnosis Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and upload it to your online application.

Should you have any questions regarding the form, please contact The Operation Baby Foundation at:

info@operationbaby.org

PART I: CONTACT INFORMATION

Patient
First Name _____ **Middle Initial** _____ **Last Name** _____ **Age** _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Home Street Address

_____ City

_____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

☐ Home Telephone ( ) _____ ☐ Cell Phone ( ) _____ ☐ Email _____

Partner
First Name _____ **Middle Initial** _____ **Last Name** _____ **Age** _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

☐ Home Telephone ( ) _____ ☐ Cell Phone( ) _____ ☐ Email: _____

Fertility Clinic _____

Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Telephone ( ) _____ Email: _____

Physician
First Name _____ **Last Name** _____

PART II: PATIENT DIAGNOSIS

MEDICAL INFERTILITY

Is the patient diagnosed with medical infertility? ☐ Yes ☐ No

If yes, how long has the patient suffered from medical infertility?

Dates (mo/yr)

Since____/____

Physician Comments _____

_____
_____
_____
_____
_____
_____
_____
_____

PART III: PATIENT INFERTILITY HISTORY

PRIOR INFERTILITY TESTING AND TREATMENT

* Have you had prior infertility testing or treatment ? ☐ Yes ☐ No

Prior Treatment (check all that apply):

	# of cycles	**Dates (mo/yr) (mo/yr)**	**Outcome**
☐ Intrauterine insemination:	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Daily fertility drug injections with insemination?: Maximum # vials per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ # embryos transferred__ # frozen___ 2. # eggs___ # embryos transferred__ # frozen___ 3. # eggs___ # embryos transferred__ # frozen___ 4. # eggs___ # embryos transferred__ # frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
Canceled in vitro fertilization attempt(s):	_____		

☐ Any other prior treatment (describe):

_____

PART IV: PLANNED FERTILITY TREATMENTS

Is the patient planning future fertility treatments through your clinic? ☐ Yes ☐ No ☐ Unsure

Physician Comments _____

PART V: SIGNATURE & CONSENT

I understand the contents of this form and agree to allow The Operation Baby Foundation to use the information provided for the purpose of determining grant recipients. I give consent to The Operation Baby Foundation to contact my fertility clinic or physician for further clarification regarding my infertility diagnosis if necessary. I certify that I have provided accurate information in this application to the best of my knowledge. The Operation Baby Foundation reserves the right to rescind a grant offer if it is determined that the information in this form is found to be inaccurate or misleading.

PATIENT'S SIGNATURE_____ **DATE** _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE _____ **DATE** _____