THIRD PARTY CONSULTATION INFORMATION SHEET

Appointment Date: _____Time:_____ Location: _____

Name(s): _____

Age(s): _____

Physician: _____Nurse:_____

Clinical Coordinator:_____

Outside Agency/Clinic (if applicable): _____

Are you a: ___Recipient _____Donor _____Gestational Carrier ____Intended Parent

Treatment Type
___Donor Egg: _____Known ____Anonymous

___Donor Sperm: _____Sperm Bank ____Known ___Donor Egg and Donor Sperm

___Donor Embryo: _____Donor ___Recipient ____Intended Parent

____GC: _____Agency __Known _____Recruited

____Other _____

Are you currently parenting? If so, please check: through birth_____, adoption _____, step children _____, Foster children_____. Ages: _____

Please list some things you would like to get out of the session/issues or concerns/information you need?

Are you interested in opportunities to attend a support group?