Reproductive Medicine & Infertility Associates

GESTATIONAL CARRIER APPLICATION & MEDICAL/GENETIC HISTORY

**Please complete form using black or blue ink. Do not use white-out.*
If you wish to change something, just cross through it with a single line.

To: Prospective Gestational Carrier (G.C.)

All prospective gestational carriers must complete this medical history questionnaire. It is important that you answer each and every question to the best of your ability. Leave no question unanswered. We thank you for your honesty in supporting our efforts to maintain a safe Gestational Carrier population for our community.

G.C. Applicant Name (Printed): G.C. Applicant Signature: Date:

If you are married, please provide the following information for that person:

Printed Full Name (First, M.I., Last): Date of Birth:

Intended Parents:_____

.....

☐ **OK to proceed/ fwd to Gen.**
☐ **Not acceptable**

_____ _____
Signature of RMIA Physician Doing Initial Review (if required) **Date**

INSTRUCTIONS: Please print all of the requested information. Write "NA" in blanks that are not applicable. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships, such as "first cousin through my mother's sister." Please provide information on all relatives requested. You do not need to list names. If you have questions, please contact the clinic at 651-222-6050 or 1-800-440-7359.

PERSONAL INFORMATION Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone(s): _____ Home _____ Cell _____ Work

Email: _____

Messages should be left at: _____ Date of Birth: _____ Age: _____

Place of Birth: _____ Social Security Number: _____

Height: _____ inches Weight: _____ pounds Race: _____

Blood type (if known): ☐ A ☐ B ☐ AB ☐ O Rh: ☐ Positive ☐ Negative

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Have you been a Gestational Carrier in the past? _____
If yes, provide details:_____

Have you ever been convicted of a crime: ☐ Yes ☐ No
If yes, for what crime: _____
If yes, did you spend any time in jail/prison: ☐ Yes ☐ No

Legal Partner Information:

Legal Name:_____ **Date of birth:**_____
Race:_____
Address:_____
_____
Phone:_____
Email:_____

DONOR RISK FACTOR HISTORY

Please check either Yes or No; and if Yes, please explain if requested.

1. Are you presently taking any prescribed medications? ☐ Yes ☐ No
   If yes, please specify what and why: _____

2. Have you taken any prescribed medications (other than noted in #1) within the last six weeks? ☐ Yes ☐ No
   If yes, please specify what and why: _____

3. Have you ever used marijuana or other illegal drugs? ☐ Yes ☐ No
   If yes, what, when and how often? _____

4. Do you use tobacco? ☐ Yes ☐ No If yes, for how long? _____ How much do you use daily? _____

5. Have you ever had or been treated for any form of sexually transmitted disease, including syphilis, gonorrhea or chlamydia?
   ☐ Yes ☐ No If yes, specify: _____

6. Did you exhibit any of the following conditions within the preceding 12 months?
   Dysuria (painful urination) ☐ Yes ☐ No
   Urethral Discharge ☐ Yes ☐ No
   Genital Ulcer ☐ Yes ☐ No

7. In the preceding six months, did you have a sexual partner who had a Trichomonas infection? ☐ Yes ☐ No

8. Have you ever experienced any of the following conditions?
   Genital Herpes ☐ Yes ☐ No If yes, list date _____
   Genital Warts ☐ Yes ☐ No If yes, list date _____
   Hepatitis ☐ Yes ☐ No If yes, list date _____

9. In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurred regularly) with anyone who has had?
   Genital Herpes ☐ Yes ☐ No
   Genital Warts ☐ Yes ☐ No
   Chronic Hepatitis (carrier) ☐ Yes ☐ No

10. In the preceding 12 months, have you undergone tattooing? ☐ Yes ☐ No If yes, list date _____

11. In the preceding 12 months, have you had acupuncture/ear piercing/body piercing/electrolysis? ☐ Yes ☐ No
    If yes, identify type and list date(s): _____

12. Have you ever been previously excluded from blood donation? ☐ Yes ☐ No
    If yes, identify the reason and date(s): _____

13. Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)? ☐ Yes ☐ No

If yes, explain _____

14. Have you had a blood transfusion in the preceding 12 months? ☐ Yes ☐ No
If yes, explain _____

15. Were you bitten by an animal suspected of rabies in the preceding 12 months? ☐ Yes ☐ No
If yes, when:_____ explain _____

16. Have you been diagnosed with Creutzfeldt-Jakob disease or do you have any blood relatives with non-iatrogenic Creutzfeldt-Jakob disease? ☐ Yes ☐ No
If yes, explain _____

17. Do you have any history of dementia or degenerative neurologic disorders of viral or unknown etiology? ☐ Yes ☐ No
If yes, explain _____

18. Have you received a transplant of human dura mater? ☐ Yes ☐ No
If yes, explain _____

19. Have you been diagnosed with West Nile Virus, encephalitis or meningitis of viral or unknown cause? ☐ Yes ☐ No
If yes, explain _____

20. Did you have a vaccination or immunization in the preceding 12 months, including the Flu or Covid vaccination? ☐ Yes ☐ No
If yes, explain _____

21. In the preceding 12 months, did you have sex or close contact with someone who received the smallpox vaccine? ☐ Yes ☐ No
If yes, explain _____

PERSONAL MEDICAL HISTORY

Allergies (medicines, food, pollen, etc)? ☐ Yes ☐ No

If yes, please list substance and reaction caused: _____

List any childhood allergies that you have outgrown: _____

Latex Allergy? ☐ Yes ☐ No
Needle Phobia? ☐ Yes ☐ No

Have you had any other operations/surgical procedures: ☐ Yes ☐ No

If yes, please complete: Year Type of Operation/Surgical Procedure

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized other than for surgery? ☐ Yes ☐ No

If yes, please complete: Year Type of Illness

_____ _____
_____ _____
_____ _____

Have you ever had any serious illness? ☐ Yes ☐ No
If yes, please explain:_____

Are you currently under a physician's care for any reason? ☐ Yes ☐ No
If yes, please explain:_____

Do you have any health problems that were not covered in the previous questions? ☐ Yes ☐ No
If yes, please explain: _____

List all current medications (include prescription, nonprescription, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all drugs you have taken in the preceding 12 months that were not listed above (including recreational drugs)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been treated for any form of cancer? ☐ Yes ☐ No
If yes, please explain (include cancer diagnosis and type of treatment): _____

Have you or any of your sexual partners ever had:

Gonorrhea	Myself:	☐ Yes	☐ No	If yes, when_____
	Partner:	☐ Yes	☐ No	If yes, when_____
Chlamydia	Myself:	☐ Yes	☐ No	If yes, when_____
	Partner:	☐ Yes	☐ No	If yes, when_____
HPV	Myself:	☐ Yes	☐ No	If yes, when_____
	Partner:	☐ Yes	☐ No	If yes, when_____
Herpes	Myself:	☐ Yes	☐ No	If yes, when_____
	Partner:	☐ Yes	☐ No	If yes, when_____
Other sexually Transmissible diseases	Myself:	☐ Yes	☐ No	If yes, when_____
	Partner:	☐ Yes	☐ No	If yes, when_____

How many sexual partners have you had sexual activity with in the last: Week _____ Month _____ Year _____

Have you ever used or do you currently use any of the following drugs?

Marijuana	☐ Yes ☐ No	If yes, Frequency/Year(s)_____	How Used_____
Cocaine	☐ Yes ☐ No	If yes, Frequency/Year(s)_____	How Used_____
Narcotics/Opiates (Heroin, Methadone, fentanyl, Opium, Morphine, Codeine)	☐ Yes ☐ No	If yes, Frequency/Year(s)_____	How Used_____
Amphetamines	☐ Yes ☐ No	If yes, Frequency/Year(s)_____	How Used_____
Other (Please Explain)	☐ Yes ☐ No	If yes, Frequency/Year(s)_____	How Used_____

Do you drink alcoholic beverages: ☐ Yes ☐ No
Approximately how many drinks per day or week do you consume?_____

If you drink less than 3 drinks per day, was there ever a time when you drank more? ☐ Yes ☐ No
If yes, how much_____ When (give years)_____

Have you ever been in an alcohol or substance abuse program? ☐ Yes ☐ No

Gynecologic History:

Age at onset of menses _____

# of days from beginning of one cycle to the beginning of the next (naturally, not on birth control): Average:_____ Range: _____

Length (# of days) of menstrual flow: _____

First day (date) of last menstrual period: _____ First day (date) of previous menstrual period: _____

Describe any menstrual problems: _____

Most Recent Pap Smear: _____ Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, have your subsequent Pap smears been normal? ☐ Yes ☐ No

Have you ever been treated for infertility? ☐ Yes ☐ No

Contraceptive History:

Currently use: _____IUD _____Condom _____Birth Control Pills _____Birth Control Patch

_____Depo-Provera _____Permanent Sterilization (e.g. tubal ligation)

If Birth Control Pills/Patch, how long have you been taking/using them? _____

Pregnancy History:

Total #: Pregnancies (confirmed) _____ Living Children _____ Full-term _____ Premature _____

Stillborn _____ Miscarriages _____ Ectopics _____ Elective Abortions_____

Length of time it took you to get pregnant. Shortest_____ Longest_____

Currently breastfeeding? ☐ Yes ☐ No

Date:	C/S or Vaginal Delivery:	Weeks of Gestation:	Baby Weight:	Baby Sex:	Complications:

OB/GYN clinic and physician (*REQUIRED*):

Clinic Name: _____ Physician name: _____

Location: _____

General Medical History/Review of Systems

Please indicate with a check mark (T) whether you currently have, have had in the past, or have ever been treated for:

Yes	No		Yes	No	
☐	☐	blood transfusion	☐	☐	cancer
☐	☐	kidney stones	☐	☐	high blood pressure (hypertension)
☐	☐	urinary tract infection	☐	☐	diabetes
☐	☐	renal (kidney)disease	☐	☐	tendency to bleed or bruise easily
☐	☐	psychiatric disorders	☐	☐	neurological disorder
☐	☐	heart problems	☐	☐	headaches, dizziness
☐	☐	eye problems	☐	☐	ear infection or problems
☐	☐	skin infections or disease	☐	☐	nose, throat or mouth problems
☐	☐	breast lumps or discharge	☐	☐	chest problems (e.g., pneumonia, cough, infections)
☐	☐	bone or joint problems	☐	☐	back problems
☐	☐	gastrointestinal problems	☐	☐	recent unexplained weight gain or loss
☐	☐	Tb or exposure to Tb	☐	☐	blood clots

If yes for any of the above, please explain:_____

_____

_____

_____

_____

FOR OFFICE USE:

If prospective gestational carrier had c-section or abdominal surgery, obtain following before routing to MD for review:

□ *Operative report(s)* □ *Intended parents chart*

□ *This completed form*

If no previous cesarean section deliveries, route this form with intended parents chart to MD for review.

□ *Intended parents chart*

□ *This completed form*

MD to complete:
□ Sono/TT first
□ Prescreen for Program Start

Zika Virus Addendum Questions

1. Have you ever been diagnosed with a Zika virus infection in the past 6 months? ☐ Yes ☐ No

2. Have you resided in, or traveled to an area with active Zika virus transmission within the past 6 months? (refer to http://www.cdc.gov/zika/geo/active-countries.html) ☐ Yes ☐ No

3. Have you had sexual intercourse within the past 6 month with a male who is known to have either been diagnosed with the Zika virus or has resided or traveled to an area with active Zika virus transmission within the past 6 months? ☐ Yes ☐ No

Questions reviewed by:_____ Date:_____

reproductive medicine and infertility associates

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in RMIA's Notice of Privacy Practices. RMIA is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of RMIA's Notice of Privacy Practices.

Patient Printed Name: _____ Patient Chart #: _____

Patient Signature: _____ Date: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____ _____

Patient Representative Signature: _____ Date: _____

ENTITY USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

_____

Signature: _____ Date: _____

Reproductive Medicine & Infertility Associates

CONTACT PREFERENCE & HIPAA CONSENT TO LEAVE MESSAGES

Reproductive Medicine & Infertility Associates (RMIA) gives patients the option to choose a preferred method in which to communicate medical information. Please choose **one** of the options below:

- ☐ Cell: _____
- ☐ Home: _____
- ☐ Work: _____
- ☐ Partner Cell: _____

☐ I give RMIA permission to leave messages regarding my medical care and treatment at the number provided above.

☐ I do NOT give RMIA permission to leave messages regarding my medical care and treatment at the number provided above. RMIA will only leave a message asking me to return the call.

I understand that RMIA will be communicating medical information regarding my care and treatment with RMIA by using the selected method above, and may leave a message, unless otherwise notified by myself or RMIA.

_____	7642-_____
Patient Printed Name	Patient ID#
_____	_____
Patient Signature	Date
_____	7642-_____
Partner Printed Name	Partner ID#
_____	_____
Partner Signature	Date

EMAIL CONSENT FORM

Patient's Name (printed)	DOB	Clinic ID number

Patient's e-mail address

EMERGENCY PROBLEMS
E-mail should never be used for **emergency situations.** In the event of an emergency, call 911

URGENT PROBLEMS
E-mail should never be used for **urgent situations**. In these cases, the patient should call our main number 651-222-6050 during business hours (M-F 7:30-4:30). After hours you can contact our on call answering service or go to an urgent care.

1. **RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR CLINIC**
   Reproductive Medicine & Infertility Associates referred throughout this consent as "Clinic."

   The Clinic offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patient should consider before using e-mail to communicate with the Clinic. These include, but not limited to, the following risks:
   - E-mail can be circulated, forwarded, and stored in numerous paper and electronic files
   - E-mail sender can type in the wrong email address
   - Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
   - Employers have a right to archive and inspect e-mails transmitted through their system.
   - E-mails can be used to introduce viruses into computer systems
   - E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
   - E-mails can be used as evidence in court.

2. **CONDITIONS FOR THE USE OF E-MAIL**
   Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, the Clinic cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure and confidential information that is not caused by the Clinics intentional misconduct. Thus, patient must consents to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:
   a) All e-mails concerning diagnosis or treatment will become part of the patients medical records.
   b) Patient shall not use e-mails for medical emergencies, urgent problems or other sensitive matters.
   c) If the patient has not received a response back from the Clinic within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
   d) The patient acknowledges the risk in using e-mail for communication regarding sensitive medical information, such as information regarding, but not limited to laboratory testing, mental health, or health history.
   e) The patient is responsible for protecting his/her password or other means of access to e-mail. The Clinic is not liable for breaches of confidentiality caused by the patient or any third party.
   f) Clinic shall not engage in e-mail communication that is unlawful.
   g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS**

To communicate by e-mail, the patient shall:

a) Limit or avoid use of his/her employer's computer
b) Inform Clinic of changes in his/her e-mail
c) Put the patient's name in the body of the e-mail.
d) Include the category of the communication in the e-mail's subject line
e) Review the e-mail to make sure it is clear and that all relevant information is provided before sending the e-mail.
f) Take precautions to preserve the confidentiality of the e-mail, such as using screen savers and safeguarding his/her computer password.

4. **ALTERNATE FORMS OF COMMUNICATION**

I understand that I may also communicate with the Clinic via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. Appointment should be made to discuss any new issues as well as sensitive medical information. I also understand that the Clinic also utilizes Notify MD as I go through active treatment and that is also a way to communicate results and changes in my treatment plan.

5. **TYPES OF E-MAIL TRANMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE**

The types of information that can be communicated by e-mail with the Clinic include prescription refills, patient referrals and appointment scheduling reminders and requests, billing and insurance questions, consultation summaries, signed consent forms, **IVF treatment plan (calendar) and instructions,** and patient education. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should call the Clinic to schedule an appointment. If you elect not to provide us with your email, but contact us through e-mail, we will correspond to any email sent to us.

In most occasions, you will receive an encrypted email via ZixMail. You must provide a username and password to log into ZixMail to retrieve your message(s). The Clinic will be notified of any message not picked up. The Clinic will make one attempt to resend via ZixMail or will mail document(s) to you. **If you do not receive our email(s), please check your spam or junk mail folder. If you find it there, please identify it as "non-junk" or "non-spam" email. You may also want to add noreply@rmia.com to your contact or 'Safe Sender' list so that these emails do not go to your junk mail folder.**

6. **SECURITY MEASURES USED BY CLINIC**

As stated above, communication via e-mail does come with privacy risks as stated above. While the Clinic can not guarantee total confidentiality, the Clinic will use reasonable safeguards to protect your health information as required by law.

7. **HOLD HARMLESS**

I agree to hold harmless the Providers, Reproductive Medicine & Infertility Associates, its employees, and website designers against all losses, expenses, damages, costs, including attorney's fees, relating to information loss due to technical failure. The Clinic does not warrant that the functions contained in any material provided will be uninterrupted or error-free, that defects will be corrected, or that the Clinic website or server that makes such site available is free of viruses or other harmful components.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Clinic representative and we acknowledge that I have read and fully understand the consent form. We understand the risks associated with the communication of e-mail between the Clinic and us, and consent to the conditions herein.

Date: _____ _____ 7642-_____
Patient Signature Clinic ID

Date: _____ _____ 7642-_____
Partner Signature Clinic ID

TO BE SIGNED BY PATIENT

reproductive medicine and infertility associates

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Reproductive Medicine &Infertility Associates (RMIA). Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this Authorization below.

This Authorization is voluntary and only applies to protected health information related to medical care received by RMIA. Treatment or payment for services are not conditioned on signing the authorization.

I understand that the information that is used or disclosed in accordance with this Authorization may be subject to re-disclosure by the Recipient(s) listed below and, in that case, will no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time prior to its expiration date by providing written notification to Michael Stein, Privacy Officer, Reproductive Medicine &Infertility Associates, 2101 Woodwinds Drive, Suite 100, Woodbury, MN 55125, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that RMIA took before it received the revocation.

This Authorization shall remain in effect until either: (a) its expiration date of 1 year, on _____ or (b) RMIA receives a written revocation of the authorization.

ACCEPTANCE

☐ I, _____, hereby authorize the use or disclosure of my protected health information to the following person(s):

NAME OF PERSON #1 _____

NAME OF PERSON #2 _____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

DECLINATION

☐ I, _____, hereby decline authorization to use or disclose my protected health information to anyone. *(Patient must also sign "HIPAA Request for Limitations & Restrictions of PHI" ED-597)*

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

I authorize continuation of this release (authorization will be valid for another year):

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

TO BE SIGNED BY
PARTNER, IF APPLICABLE

reproductive medicine and infertility associates

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Reproductive Medicine &Infertility Associates (RMIA). Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this Authorization below.

This Authorization is voluntary and only applies to protected health information related to medical care received by RMIA. Treatment or payment for services are not conditioned on signing the authorization.

I understand that the information that is used or disclosed in accordance with this Authorization may be subject to re-disclosure by the Recipient(s) listed below and, in that case, will no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time prior to its expiration date by providing written notification to Michael Stein, Privacy Officer, Reproductive Medicine &Infertility Associates, 2101 Woodwinds Drive, Suite 100, Woodbury, MN 55125, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that RMIA took before it received the revocation.

This Authorization shall remain in effect until either: (a) its expiration date of 1 year, on _____ or (b) RMIA receives a written revocation of the authorization.

ACCEPTANCE

☐ I, _____, hereby authorize the use or disclosure of my protected health information to the following person(s):

NAME OF PERSON #1 _____

NAME OF PERSON #2 _____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

DECLINATION

☐ I, _____, hereby decline authorization to use or disclose my protected health information to anyone. *(Patient must also sign "HIPAA Request for Limitations & Restrictions of PHI" ED-597)*

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

I authorize continuation of this release (authorization will be valid for another year):

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____