Patients First and Last Name:____

Form to be Completed by Physician's Office (page 1 of 3)

If you are requesting funds for adoption please ask your physician to write a letter stating that you have infertility and the cause of your infertility. If you are requesting a grant for fertility treatment (including fertility treatment with your own eggs and or sperm, gestational carrier, egg donation or adoption or embryo donation or adoption) please have your doctor complete the following forms. Physicians should return the forms to the Cade Foundation at the address/ fax number below once they have completed the forms. **Completed forms are due by 2/1 or 7/1 deadlines.**

Seeking grant for fertility treatment for the following: (check the appropriate):

____ IVF ____ Egg Donor ____ IUI ____ ICSI ____ Adoption ____ Other: ___________

Likelihood of success of proposed fertility treatment: ______________

Name of Clinic: ____

Phone Number: ____

Name of person completing this form from clinic: _______________________

Signature: ____

Date:____

Tinina Q. Cade Foundation, Inc. * 10211 South Dolfield Road * Owings Mills, MD 21117
Telephone: (410) 998-1000 * Fax (410)741-3701* www.cadefoundation.org
OVERCOMING Infertility!

Form to be Completed by Physician's Office (page 2 of 3)

FEMALE MEDICAL HISTORY (for applicants applying for a grant for fertility treatment only.)
Age: ________ Height_________ Weight: _________________________

Does this patient have infertility (CIRCLE ONE)? YES NO

Length of time of currently attempting pregnancy: ________________________

Cause of Infertility, if known: ____

Gynecologic History:
History of surgeries: ____
____

History of endometriosis: ________________pelvic infections________________

Obstetrical History:

Pregnancy #	Year	Full Term	Pre-Term	Miscarriage	Termination

Previous Infertility Testing:
HSG Results: ________________Laparoscopy: _______________________________
Hysteroscopy: ________________Other gynecological surgery: ______________
Ultrasound results: _____________Do you have fibroids? ___________________
Do you have endometriosis? _________ Stage ______________________________
Hormone testing:
Date: Day #3 FSH____E2 (Estradiol) ________AMH_________________
Treatment with Clomid: ___How many cycles? ________IUI ________________
Treatment (Gonadotropins : Gonal F, Follistim, Bravelle, Menopur) _________
Number of IVF cycles? ______________________ IUI Cycles______________________

IVF Cycles: Please list the numbers of cycles, numbers of eggs retrieved, pregnancies.
Please include all stimulation results and embryology results if available.
____
____

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MALE MEDICAL HISTORY (for fertility treatment grant applications only)

Does this patient have infertility (CIRCLE ONE)? YES NO

Length of time of currently attempting pregnancy: ______________________

Cause of Infertility, if known: ____

Age: ____________ Height: ___________ Weight: ________________

Medical Problems: ____
____
____

Surgical History: ____

Sperm Analysis: Date: ____ Count: ______ Motility: ______ Morphology: _______

Current Medications: ____

Have patient ever been treated for cancer? Yes No Medications? __________________

Instructions to Clinic:
Please fax this completed form (pages 1-3) to 410-741-3701 OR scan and email it to admin@cadefoundation.org.

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