



**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: \_\_\_\_\_



**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.

\_\_\_\_\_  
\_\_\_\_\_



**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](mailto:admin@cadefoundation.org).**