GESTATIONAL SURROGACY INTAKE

Client (Husband and Wife) **File No.:**
Address:

County:
Home phone:
Work phone (Husband): Work phone (Wife):
Fax:
e-mail:

Husband
Name:
Social Security No.:
Birth date:
Birthplace:
No. of years in state:
Date and place of marriage:
Prior marriages:
Sperm: Husband's ☐ Donor's ☐

Wife
Name:
Maiden name:
Social Security No.:
Birth date:
Birthplace:
No. of years in state:
Prior marriages:
Eggs: Wife's ☐ Surrogate's ☐ 3d Party Donor's ☐

Psychological and medical testing conducted:

Gestational Surrogate
Name:
Address:

Phone:
Birth date:
Marital status:
Husband's name:
Prior live births:

Private insurance or Medicaid:
Psychological and medical testing conducted:

Doctor: _____ Phone: _____

Address: _____ Fax: _____

_____

_____ Hospital: _____

Anticipated transfer date:

Number of embryos expected to be transferred:

Number of cycles expected to be attempted:

Mental Health Professional: _____

Address: _____ Phone: _____

_____ Fax: _____

Willing to provide counseling/serve as dispute mediator? Yes □ No □

Direct expenses (payable by Intended Parents):
(including OB/GYN, surrogate's hospital, child's hospital and any physician or third party provider bills incurred in connection with fertility, pregnancy, labor, delivery and birth)

Living expenses
Total Stipulated Amount: $ _____
Schedule of payments: Monthly / Trimester (circle one)

First Payment (at confirmation of pregnancy): $ _____

Monthly/Trimester payment amount: $ _____

Balance: $ _____ due after delivery: ____ days postpartum

Extra for additional child: $ _____

Travel / lodging for procedure / pregnancy: $_____ one-time/monthly or ____¢ per mile

Maternity clothes: □ As needed -OR- $ _____ disbursed: □

Psychological counseling: payment of deductible or cap: $ _____
(up to 6 wks. after birth)

Lost wages: $_____/week (see disability insurance, below)
(in event of physician-required bedrest)

Child care: $_____ /week
(in event of physician-required bedrest)

Housekeeping, etc.: $_____/week
(in event of physician-required bedrest)

Insurance:

Medical paid by Intended Parents:
(extending up to six weeks after birth)

Term life insurance: Amount:
(extending up to six weeks after birth)

Disability insurance (in lieu of lost wages, etc.):
(extending up to six weeks after birth)

Selective Reduction (multiple fetuses):
We intend that Surrogate carry no more than ____ fetuses to term in the event of a multi-fetal pregnancy (twins, triplets, etc.).

Attorneys' Fees of Surrogate:

For review/negotiation of contract: cap: $_____

For will/codicil/living will: cap: $_____

Identities confidential?

OFFICE USE:
Date of Affirmation of Parental Status hearing:
(petition filed within 3 days of birth)

PHYSICIAN'S STATEMENT

(Please have your fertility physician provide the following statement on letterhead for filing with the court. The physician's statement may select among the following conditions specified in the applicable Florida statute but must include at least one of the conditions.)

_____ is my patient and I have determined, within a reasonable degree of medical certainty, that she cannot physically gestate a pregnancy to term, or the gestation will cause a risk to her physical health, or the gestation will cause a risk to the health of the fetus.