Pacific Reproductive Services

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MEDICAL CERTIFICATION

Dear Clinician:

Recipients of Pacific Reproductive Services donor sperm are required to undergo a pre-pregnancy physical examination and review of personal and family medical history to rule out contraindications to pregnancy. Please perform these examinations as you deem appropriate and then counsel the patient about any pertinent findings that could cause complications during her pregnancy or health problems for her child.

_____/_____ _____/_____/_____ _____/_____/_____
Patient Last Name First Name DOB Date Of Exam

The following laboratory tests are recommended, but not required:

PAP Smear	Gonorrhea Culture	Syphilis Serology
Chlamydia Screening	Hepatitis B Antigen	HIV 1

The results of tests DO NOT need to be sent to Pacific Reproductive Services.

MEDICAL CERTIFICATION

I certify that I have performed a pre-pregnancy history, physical and laboratory examination of the above-named patient as I have deemed appropriate. I find no significant contraindications to her becoming pregnant. I have counseled her about any of my findings that could indicate possible complications for her during pregnancy or for her child. ***Please release to her the desired number of semen or sperm specimens for the donor of her choice.***

I ☐ will ☐ will not be performing reproductive procedures on this patient.

I am a: ☐ Physician ☐ Nurse Practitioner ☐ Nurse Midwife ☐ Physician Assistant

☐ Other: _____

_____/_____/_____/ _____
Signature Print Name License # State

_____
Address/City/State/Zip

(____)_____ _____
Telephone Specialty