Medical Clearance for Surrogate

(Must be completed by an M.D. or D.O.)

Practice Name and Address

(Office Stamp Preferred)

Your current patient, _____, has applied to become a surrogate. As part of the screening process, we request that she receive medical clearance from her current physician overseeing her obstetrical and gynecological care.

Please provide a copy of her most recent pap smear lab report, history and physical, and mammogram report (if applicable).

Review the following questions and provide the most appropriate answer based on your knowledge of her health history.

- Date and results of current pap smear: _____
- When do you recommend the next pap smear be performed? _____
- Please confirm your patient's height _____ and weight_____
- If > 39 years of age, date and results of most recent mammogram_____
- Do you confirm that your patient is healthy and can safely carry a pregnancy? YES NO
- Do you medically clear this patient to become a gestational carrier? YES NO
- Do you have and concerns regarding the above? Please describe:

Physicians Signature (Must be signed by an M.D. or D.O.) _____

Physicians Name (Print) _____

Date _____

Please fax this form to (919) 248-8776