

# Medical Records Checklist

## Gestational Carrier

Thank you for your partnership with ORM Fertility. We ask that you gather the records and present them only when they are complete. Additionally, we ask that you include all records for any screening or treatment performed at a REI clinic.

Please include any explanation or outcome information on previous carrier attempts.

**Please send completed Gestational Carrier Medical Records to [GCReview@ormfertility.com](mailto:GCReview@ormfertility.com)**

### Gestational Carrier Intake Information

Agency Name \_\_\_\_\_ Agency Contact (Name & Email) \_\_\_\_\_  
Carrier Full Legal Name \_\_\_\_\_ Carrier DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Carrier Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Carrier Phone \_\_\_\_\_ Carrier Email \_\_\_\_\_  
Partner Full Legal Name \_\_\_\_\_ Partner DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Partner Phone \_\_\_\_\_ Partner Email \_\_\_\_\_  
IP Name(s) \_\_\_\_\_

**Please check which required records are included. Please included comments if needed.**

Records Included	Additional Comments
<input type="checkbox"/> Current application and/or profile	
<input type="checkbox"/> Height & weight - validated by the gestational surrogacy agency. Please note: If BMI greater than 35, cycle may be cancelled.	
<input type="checkbox"/> Psychological evaluation, if complete	
<input type="checkbox"/> Prenatal and delivery records from most recent Pregnancy #1	
<input type="checkbox"/> Prenatal and delivery records from most recent Pregnancy #2	
<input type="checkbox"/> If available, most recent or up to date pap smear and any/all follow up treatment records for any abnormal pap.	
<input type="checkbox"/> Annual exam within the last 3 years ( <i>only required if no prenatal records in the last three years</i> )	
<input type="checkbox"/> Specialist records or other records (e.g. <i>neurology, hematology, cardiology, endocrinology, maternal-fetal medicine</i> ) if applicant has seen a specialist at any time for any reason	
<input type="checkbox"/> Covid Vaccination Record	
<input type="checkbox"/> Confirm BMI	
<input type="checkbox"/> Confirmed current medication	

\*Please note: Agencies may provide the above medical records using internal forms if preferred.