North Carolina Center for
Reproductive Medicine

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Embryo Adoption Application

Please print and fill out.
Return to NCCRM 400 Ashville Ave #200 Cary NC 27518
Phone (919) 233-1680 Fax (919)233-1685

Confidential Medical History

How did you learn about NCCRM's embryo adoption program?
____

Were you referred by anyone?____

Female Partner Information

Name:____

Date of Birth:______________________________

Home Street Address:____

City:_____________________ State:_____________ Zip code______________________

Home Phone:(____)____

Work Phone: (____)____

Cell Phone: (_____)____

Email Address:____

What is your preferred method of contact:_______________________________________

Social Security #:____

Employer or School:____

Occupation or Majors/Minors:____

Years of Education/Degrees:____

Health Insurance Information:

Insurance Carrier:____

Policy Holder's Name:____________________________D.O.B.______________

ID#:_____________________________ Group #:________________________

Phone # of Insurance Company:_______________________________________

List the country, state and county of origin of most of your ancestors and yourself:

Country:____

State:____

County:____

Do you have any health problems? ________ Yes _________ No

If yes, please explain and give age of
diagnosis:____

____

Hospitalization? __________ Yes ___________ No

If yes, please give dates and for what reason(s):_____________________________

____

Surgical History:__________ Yes ___________ No

Why?____

____

Obstetrical History:

Any previous fertility treatment:____

____

Pregnancies:____________ Yes ______________ No

Miscarriages: ___________ Yes ______________ No

Stillbirths:______________ Yes ______________ No

Gynecologic Surgery:________________ Yes ______________ No

Why:____

Any complications?:____

____

Number of children with current partner:_____________________________________

Number of children with previous partner(s):__________________________________

Male Partner Information

Name:____

Date of Birth:____

Home Street Address:____

City_______________________ State:_______________ Zip code:________________

Home Phone: (______)____

Work Phone: (______)____

Cell Phone: (______)____

Email Address:____

What is your preferred method of contact:_____________________________________

Social Security#:____

Employer or School:____

Occupation or Majors/Minors:____

Years of Education/Degrees:____

Health Insurance Information:

Insurance Carrier:____

Policy Holders Name:________________________________D.O.B.________________

ID#:_________________________________ Group #:___________________________

Phone # of Insurance Company:____

List the country, state and county of origin of most of your ancestors and yourself:

Country:____

State:____

County:____

Do you have any health problems? _________ Yes __________ No

If yes, please explain and give age of
diagnosis:____

____

Hospitalization? ___________ Yes ____________ No

If yes, please give dates and for what reason(s):_________________________________

____

Surgical History:___________ Yes ____________ No

Why?____

____

Number of children with current partner:_____________________________________

Number of children with previous partner(s):__________________________________

Adopting Couple's Physical Characteristics:

Male Partner	**Female Partner**
Height:________________________	Height:________________________
Weight:_______________________	Weight:________________________
Eye Color:____________________	Eye Color:_____________________
Hair Color:____________________	Hair Color:_____________________
Hair Texture:__________________	Hair Texture:___________________
Race:_________________________	Race:__________________________
Blood Type (A,B,O):______________	Blood Type (A,B,O):_____________
RH (+,-):_______________________	RH (+, -):______________________

Please attach a picture of both of you (recipient couple):

Characteristics Adopting Couple Desire of Their Embryo Donor:

In order to facilitate matching your embryo donor, please indicate the importance of the characteristics below on a scale of 1 – 5, with 1 being the least important and 5 being the most important.

	(Least important)			(Most important)	
Eye Color	1	2	3	4	5
Hair Color	1	2	3	4	5
Height	1	2	3	4	5
Weight (<_________)	1	2	3	4	5
Education	1	2	3	4	5
Blood Type	1	2	3	4	5
Education Level	1	2	3	4	5

Please add comments on any of the above or add to your specifications:

Preferences for Donor's Ancestry:

_________ Chinese __________ Japanese _________ Korean ___________ Other

___________Pacific Islands ___________ Native American ________ Alaskan

___________ Middle Eastern __________ Black ____________ Hispanic

___________ Caucasian ______________ Jewish______________Does Not Matter

Skin Tone: __________ Fair __________ Medium _________ Olive _________ Dark

Are there any times that you would not be available for embryo transfer?_____________

If yes, please list dates: ____

Sign and Date Form:

The above information concerning me/us is correct based on my knowledge. I have had an opportunity to have my questions answered to my satisfaction. I hereby give permission to NCCRM to disclose pertinent information.

____

Signature of Female Partner **Date**

____

Signature of Male Partner **Date**