Medical Referral Form

Dear Physician,

Hasidah is a 501c3 non-profit focused on infertility in the Jewish community that provides grants and loans for IVF in addition to emotional support. Hasidah has received a request from one of your patients to receive financial assistance for treatment. We need your help to process their application.

We deeply respect the relationship our applicants have with their doctors as well as the medical expertise you provide. Hasidah provides funding only to clinics that report statistics to and whose reproductive endocrinologists are members of the Society for Assisted Reproductive Technology (SART) and that have acceptable success rates for appropriate procedures. *If you are not reporting to SART, please tell your patient.* We believe it is better for them to learn that from you than from us.

We pay providers directly and we expect the clinic to bill the patient directly first.

Hasidah has a medical advisory board of your peers that reviews each referral. We need to establish the following about your patient:

* Appropriate evaluation of the patient has been done
* IVF is necessary treatment (Note: Hasidah does not fund embryo banking, egg freezing, or IVF when IUI is a reasonable option)
* Patient has a reasonable likelihood of success
* Genetic screening will be performed prior to the IVF
* If donors, reciprocal IVF, or surrogacy are involved, *we need information for each person involved.*

**Please answer every item in the form below** for this applicant while keeping these factors in mind. If there are no frozen embryos for example, please write 0. If an item is not applicable, please write N/A. *Clarity and explanations are greatly appreciated*. We also respectfully ask that you consider providing a matching discount if we are able to award this applicant with a grant. All Hasidah grantees are screened for financial need.

Thank you in advance for working with us to help these families grow.

Sincerely,



Rabbi Idit Solomon

Founder and CEO

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient/Applicant Information** | | | | | | | | | |
| Applicant 1 Name: | | | | | Applicant 2 Name: | | | | |
| Treating clinic: | | | | | Doctor’s name: | | | | |
| Clinic Address: | | | | | | | | | |
| Clinic Phone: | | | | | Email: | | | | |
| **Medical information** | | | | | | | | | |
| Length of infertility (months trying)? | | | | | | | | | |
| Reason for the **necessity** of IVF/ infertility diagnosis: | | | | | | | | | |
| Semen Count: | | | | Motility: | | | Morphology | | |
| Uterine cavity: | | | | | | | | | |
| Patency of Tubes: | | | | | | | | | |
| Estradiol: | FSH: | | AFC: | | | AMH: | | | BMI: |
| Significant results from HSG, hydrosonogram or hsyteroscopy: | | | | | | | | | |
| **Fertility treatment HISTORY** | | | | | | | | | |
| **Past Treatments** | | | | **Date(s) (mm/yy)** | | **Outcome/Explanation** | | | |
| Medicated cycles: | | | |  | |  | | | |
| IUI’s: | | | |  | |  | | | |
| IVFs: | | | |  | |  | | | |
| Other: | | | |  | |  | | | |
| # Pregnancies: | | # Live births: | | | Frozen embryos: | | | Frozen eggs: | |

|  |  |
| --- | --- |
| **Medical Information Continued** | |
| Relevant past medical or fertility issues and explanation (If past multiple miscarriages, was workup done?): | | |
| Recommendation for treatment and any stipulations or considerations for treatment: | | |
| For IVF with egg donor, indicate if donor is known or anonymous, age, and AMH: | | |
| Yes/No | All participants in the IVF (females, partners, donors) will be screened with the most recent panel for general and Jewish genetic diseases. | |
| Any additional explanation or evaluation to clarify this patient’s situation: | | |

|  |  |
| --- | --- |
| **financial Assistance** | |
| **Our clinic is able to provide (check one):** | |
|  | a discount towards treatment at our facility of \_\_\_\_\_\_\_\_\_\_\_ (Please list $ or %) |
|  | a matching scholarship for Hasidah’s funding for up to $\_\_\_\_\_\_\_\_\_\_\_. |
|  | We are unable to offer this patient financial assistance. |
| **SART Compliance** | |
|  | I am a board-certified reproductive endocrinologist and will perform IVF at a clinic/lab that reports to, and therefore adheres to guidelines set forth by, SART. |

Physician Name Signature Date

Person responsible for financial assistance if other than physician:

Name Signature Date