Dear Patient,

Thank you for contacting SIRM-STL. Attached in this email you will find our required new patient paperwork and additional information about SIRM-STL. Please return the required documents no later than 3 days prior to your appointment.

In addition, we will call to confirm your appointment approximately 3 days prior to your appointment. **Please note that we have multiple office locations and it is important to confirm the date, time and location of your consultation!**

Creve Coeur Office: 555 N. New Ballas Road, Suite 150, Creve Coeur, MO 63141
St. Peters Office: 3701 N. St. Peters Parkway, St. Peters, MO 63376
Both offices have the same phone number: (314) 983-9000

It is very important that we receive your paperwork prior to your appointment. You may either fax it to 314-983-9023 or email it to us (simply reply to this email) as soon as it is completed.

In addition to your paperwork, please be sure to obtain the following items and bring it with you to your appointment (if you are able to send it in advance, we would greatly appreciate it):

1. New Patient Questionnaire to be filled out completely (attached)
2. Prior medical Records (if applicable)
3. Copies of ID's for both patient and spouse/partner
4. Copies of you insurance card(s)-if you are sending this prior to your appointment, be sure to include both front and back.

If you have any questions and/or concerns, please do not hesitate to contact us. We will be happy to help you.

Thank you again for contacting us! It will be our pleasure to see you at your appointment.

SIRM-STL

What to Expect at Your Visit

Initial Consultation with Your Physician

The purpose and goal of your initial consultation with us at SIRM-STL is two-fold; to evaluate your case as comprehensively as possible and to provide you with an individualized plan of treatment. Please plan to spend one to two hours with us, including waiting time, as you will be spending time with your physician.

Financial Consultation

After your initial consultation, a financial consultation will be performed. At this consultation your insurance coverage will be discussed; as well as the financial packages you may qualify for as offered by SIRM-STL. It is the goal of the Financial Counselor to make sure you understand all options and costs that may be incurred so that there are no financial surprises.

Prior to Cycle Start

Should you decide to pursue treatment with us, we will require a deposit to secure your spot, at which time you will be scheduled with a Nurse Coordinator to prepare you for cycle. The coordinator will make sure all necessary lab screening/diagnostic tests are completed. Prior to starting injections, all necessary lab screening/diagnostic testing must be complete, all consents must be signed, all fees paid, and insurance benefits verified.

Please ask Questions

We understand that this is an emotional, financial, and physical experience. Of course we wish everyone could have a positive outcome; however, we know that is not always possible. It is our goal to make this experience as pleasant as possible no matter what the outcome. We are here to answer all of your questions and concerns, please feel free to voice them.

Welcome to SIRM-STL Fertility Center

Welcome and thank you for choosing SIRM-STL for your treatment. This letter is to explain our office policies and procedures to ensure that you receive the best care and treatment possible. While located in Missouri, SIRM-STL has assisted thousands of couples from around the world in their desire to become a family. To make your experience with us as easy and enjoyable as possible, we have provided you with some information about our practice.

Office Mission

We are pleased that you have chosen SIRM-STL to provide your medical care. Our mission is to help infertile couples complete their journey to joyful parenthood. Through the expertise of our staff, we commit to:

- Providing our patients with the highest quality of medical care in a sensitive, compassionate, and caring environment.
- Ensuring outstanding IVF birthrates even in the most difficult cases.
- Being accessible and available to our patients.
- Making IVF affordable through the provision of creative and consumer friendly outcome-based pricing and financing for medical services.
- Taking on a leadership position as patient advocates.

We believe in the concept of providing patients with as much relevant information as possible. Our goal is to empower them to make informed decisions about their own treatment.

Office Hours

Our office locations are the following: **Creve Coeur Office: 555 N. New Ballas Road, Suite 150, Creve Coeur, MO 63141 & St. Peters Office: 3701 N. St. Peters Parkway, St. Peters, MO 63376. Both offices have the same phone number: (314) 983-9000**

Our office hours are from 8:00am-4:30pm, Monday through Friday. Patients are seen on the weekend only during cycle. No routine visits will be scheduled on the weekends. We attempt to see you at your scheduled appointment time, however occasionally situations arise which require the Physician to spend a longer than scheduled time with a patient. Please understand that when the Physician sees you, she will provide you with the same individual attention.

Telephone Calls

Our telephone hours are 8:00am-4:00pm, Monday through Friday. Phone messages and test results are reviewed by the staff daily. Nurses will answer phone calls unless they are assisting the Physician or patient. It is our policy that all calls are returned within 24 hours however, emergency calls will be evaluated immediately.

After Hours Calls

We do have a nurse available on call 24 hours a day for medical emergencies. Simply call the office phone at 314-983-9000 and you will be directed to our on-call nurse.

We are looking forward to your upcoming consultation. Please let us know if we can be of further assistance in preparing for your appointment.

Phone/Skype Consultation Payment Authorization

For your convenience, we do accept Visa, MasterCard, Discover, and American Express.

CC# _____Dollar Amount $150.00

Expiration Date ____/_____ Security Code _____

Name (as it appears on the card) _____

Skype username _____

Address _____

Signature of Authorizing Credit Card Transaction _____

By signing this form, you are authorizing us to contact you via Skype to discuss medical information.

Please sign and return this form prior to your consultation, your payment will be processed immediately

555 North New Ballas Rd. Suite 150, St. Louis, MO. 63141
Tel: 314.983.9000 Fax 314.983.9023

MEDICAL RELEASE FORM

I, _____, DOB _____, and
_____ __, DOB _____

Hereby request that all of our medical records be release to my physician at the above address.

Requesting records from:

Physicians Name _____

Address _____

Phone _____ Fax _____

Please include the following information:

-Any lab work that has been performed within the last 3 years, including confidential testing such as: FSH, Estradiol, Prolactin, TSH, Blood type/RH factor, Rubella, Cystic Fibrosis, Varicella Zoster, Hepatitis A, B, & C, HIV, HTLV, CMV, RPR, VDRL, Chlamydia, Gonorrhea, CBC, LH, Ureaplasma, MTHFR, Factor V Leiden, Testosterone, Glucose/Insulin Tests, DHEAS, Semen Analysis w/ morphology, PAP Smear, Mammogram, Chest x-ray.

-Any of the following testing/procedures: Fluid ultrasound, Hysterosalpingogram, Laparoscopy, Hysteroscopy.

-Any information relating to all prior In Vitro Fertilization cycles and/or IUI's.

Patient

Date _____

Name _____

Witness

Date _____

Name _____

Signature _____ Signature _____

SIRM®
ST LOUIS

INSURANCE INFORMATION

Patient Name	Birthdate:	Address (if different)	Home Phone #:
Do you have Medicaid	Yes or No	Do you have Medicare	Yes or No
Occupation:	Employer:	Employer Address:	Employer Phone #:

Do you currently work for a Healthcare Facility, i.e. Wash-U, SSM, Mercy (if so, please list):
_____

Please indicate primary insurance: _____Other: _____

Subscribers Name:	Subscribers SSN:	Subscribers Birthdate:	Group # and Claims Mailing (PO BOX) Address:	Policy #:	Co-Payment:

Patient's Relationship to subscriber: _____Other: _____

Name of Secondary Insurance:	Subscribers Name:	Group #:	Policy #:

Patient's Relationship to subscriber: _____Other: _____

Welcome and thank you for choosing SIRM-STL! We do ask that the above form be filled out and either emailed or faxed back to us at 314.983.9023 along with a copy of your insurance card(s). If you have any questions regarding insurance coverage, please feel free to contact us at 314.983.9000.

Thank you and we will look forward to seeing you!

SIRM®
ST LOUIS

Welcome to SIRM-STL!

We are pleased that you have chosen us to provide your medical care. Our mission is to help infertile couples complete their journey to joyful parenthood. Through the expertise of our staff, we commit to:

- Provide our patients with the highest quality of medical care in a sensitive, compassionate, and caring environment.
- Be accessible and available to our patients at all times.

CLINICAL QUESTIONNAIRE Please fill out the following questionnaire as accurately as possible. If you have difficulty completing it, please call our office. We very much look forward to your upcoming consultation.			
Patient Name:	DOB:	Age:	
Partner Name:	DOB:	Age:	
Address:			
Telephone: (Home and/or Cell- please specify)	(W)	(FAX)	
Email address:			
Social Security Number:	Spouse/Partner Social Security Number:		
How were you referred to us?			
○ Friend	○ Relative	○ Physician	○ Other (Please Specify)
OB/GYN:			
Date of Consultation:	Seeing Dr.:		

INSURANCE INFORMATION **Please fill out insurance information and make sure to send us a copy of both the front and back of the card(s)**			
Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Insurance ID#		Insurance ID#	

Group #		Group #	
Customer Service #		Customer Service #	
HMO or PPO		HMO or PPO	

If you have HMO Insurance: You must obtain a referral from your insurance company and/or your OBGYN prior to your initial consultation

OBSTETRICAL HISTORY

How long have you been trying to have a baby? Years

Have you ever been pregnant before? ○ Yes or ○ No

Date	Current /Prior Partner	Live Birth (Y/N)	Miscarriage/Abortion/ Ectopic	Wks.	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications/Comments

GYNECOLOGIC HISTORY

When was the first day of your last period?

Are your periods regular?		○ Yes	○ No
Do you have heavy or prolonged bleeding (more than 5 days)?		○ Yes	○ No
Have you ever needed medication to bring on your period?		○ Yes	○ No
Pain with menstruation?		○ Yes	○ No
Degree of pain?	○ Mild	○ Moderate	○ Severe
Pain relieved by over the counter medications?		○ Yes	○ No
Begins a few days prior to the onset of bleeding?		○ Yes	○ No
Persists more than 48 hours?		○ Yes	○ No
Do you experience pain with ovulation?		○ Yes	○ No
Do you experience pain with sexual intercourse?		○ Yes	○ No
When was your last pap smear?			
Have you ever had an abnormal pap smear?		○ Yes	○ No
Do you have a vaginal discharge? a) Non irritant b) Itching/burning		○ Yes ○ Yes ○ Yes	○ No ○ No ○ No
Do you experience paid with deep penetration during sexual intercourse?		○ Yes	○ No
Have you ever had a sexually transmitted disease? (i.e. Chlamydia, Gonorrhea, Syphilis, Herpes)		○ Yes- please specify	○ No
Was it treated?		○ Yes	○ No
Have you ever had Pelvic Inflammatory Disease (PID)? When? Was it treated?		○ Yes Month ____ ○ Yes	○ No Year ____ ○ No
Do you experience milk or discharge from your breasts?		○ Yes	○ No

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS

Do you have a history of the following conditions?

Condition	Yes/No	Comments
Migraine		
Thyroid Problems		
Asthma		
Heart Murmur		
Depression and/or Anxiety		
High blood pressure		
Gastric/duodenal ulcer		
Bleeding tendency or Blood Clots		
Problems with Anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus Erythematosis		
Neurologic disorders		
Thrombophlebitis		
Sickle cell disease		
Thalassemia		
Cancer		
Other		

DRUG ALLERGIES

Are you allergic to or have a sensitivity to Latex?	○ Yes	○ No

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications?	○ Yes	○ No

Medication	Dose	Frequency

FAMILY HISTORY

Is there a history of any of the following conditions in your family?

Condition	Yes/No	Affected Relative
Diabetes		

Heart disease		
High Blood Pressure		
Birth defects		
Inherited diseases (please specify)		
Thyroid disease		
Breast Cancer		
Ovarian Cancer		
Uterine cancer		
Rheumatoid arthritis		
Lupus Erythematosis		
Blood Clot		

SOCIAL HISTORY			
Occupation			
Do you use tobacco?	○ Yes	○ No	#Packs/day
Do you use alcohol?	○ Yes	○ No	#Drinks/week
Are you currently married?	○ Yes	○ No	

COMMENTS Please describer the nature of your problem/concern.

MALE HISTORY	Occupation:		
Have you initiated any pregnancies in the past?	○ Yes	○ No	
Number of pregnancies?			
Number with current partner?			
When was the most recent pregnancy?			
Have you been evaluated by an Urologist?	○ Yes	○ No	
Have you ever had a semen analysis?	○ Yes	○ No	
Result:	Date:		
	Count (million cell/ml)		
	Motility %		
	Morphology(%normal forms)		
	Other		
Are you allergic to any medications?	○ Yes	○ No	
Are you taking any medications? **Please specify**	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	#p/day

MALE INFERTILITY TESTS Have you had any of the following tests or procedures?

Test/Procedure	Date	Result	Comment
Blood Tests			
FSH			
LH			
Testosterone			
TSH			
Anti-sperm antibodies			
DQ Alpha/HLA			
Surgeries			
Vasectomy			
Vasectomy reversal			
Testicular Biopsy			
Varicocele surgery			
Hernia repair			
Undescended testes			
Surgical removal of testes			
Other			

PREVIOUS FEMALE INFERTILITY EVALUATION
Have you had any of the following tests or procedures?

Test/Procedure	Date	Result
Blood test (non-immunologic)		
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
LH (Cycle day 3)		
AMH		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-Progesterone		
Blood type and RH- status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/VDRL (Syphilis)		
Blood Tests (Immunologic)		
Antiphospholipid antibodies panel (APA)		
Natural Killer (NK) cell assay (K-562 test)		
DQ Alpha/HLA		
Anti-thyroid antibodies		
Pelvic Assessment		
Vaginal Ultrasound		
Hysterosalpingogram (HSG-Dye test)		

Fluid Ultrasound (Sonohysterogram)		
Hysteroscopy		
Other:		

PREVIOUS INFERTILITY TREATMENT Have you ever used any of the following medications?				
Medication	Date	Dose	# Cycles	Comments
Clomiphene Citrate (Oral)				
Letrozole				
Follistim/GonalF/Menopur/Luveris				
HCG				
Progesterone				
Heparin/Lovenox				
IVIG				
LIT				
Intralipid (IL)				
Treatment				
Intrauterine Insemination (IUI)				
In Vitro Fertilization (IVF)				
Ovum Donation (OD)				
Gestational surrogacy (GS) or egg donation (OD)				

IF YOU HAVE UNDERGONE IVF, ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. MEDICAL RECORDS CAN BE ORDERED AT A LATER DATE.

General Questions:	Response:
1. How many IVF cycles have you undergone?	Own Eggs: _____ Donor Eggs: _____
2. How many frozen embryo transfers (FET's) have you undergone?	
3. When did each cycle (using fresh or frozen embryos take place?	(MO/YR) 1. 2. 3. 4.
4. Outcomes in each Cycle: a. Negative Pregnancy Test b. Chemical Pregnancy (+ve pregnancy test without ultrasound confirmation) c. Clinical pregnancy (ultrasound confirmation) d. Miscarriage e. Molar pregnancy f. Live birth g. Still born	• • • • • • •

QUESTIONS PERTAINING TO YOUR MOST RECENT FRESH IVF ATTEMPT

General Questions	Responses
1. When did you undergo your most recent IVF?	(Month/Year)
2. Did you use oral contraceptive pills prior to cycle?	
3. Did you use Lupron (long/short) or Antagonists (Ganirelix/Cetrotide)?	
4. How many International units of gonadotropins (e.g., Follistim, Gonal F, and Menopur) were injected on the 1st, 2nd, and 3rd day of the cycle treatment?	IU/Day 1_____ IU/Day 2_____ IU/Day 3 _____
5. How many follicles were observed by ultrasound exam?	
6. What was the peak plasma E2 level on the day of HCG?	
7. What was the maximal endometrial thickness?	_____mm
8. What form and dosage of hCG did you receive as a "trigger" before the egg retrieval?	1. Profasi___Units 2. Pregnyl___Units 3. Novarel___Units 4. Ovidrel___Micrograms
9. How many eggs were harvested?	
10. Was ICSI used to fertilize the eggs?	
11. How many embryos were produced?	
12. Were cleaved embryos transferred on day 2 or 3?	
13. Were blastocysts transferred on day 5 or 6?	
14. How many embryos/blastocysts were transferred at ET?	
15. What was the quality (i.e. cell/grade) of each transferred embryo/blastocyst?	1. 2. 3. 4.
16. Were any embryos/blastocysts frozen?	o Yes o No
17. Do you have any frozen embryos left?	o Yes o No
18. Did you have any of the following immunotherapies?	
• Heparin	o Yes o No
• Lovenox	o Yes o No
• Aspirin	o Yes o No
• Medrol	o Yes o No
• Dexamethasone	o Yes o No
• Prednisone	o Yes o No
• Intralipid (IL)	o Yes o No
• IVIG, LIT, Intralipid	o Yes o No