

Updated July 2021

Please complete this form if you are applying to be an intended parent with SurrogacyUK.

HOW TO COMPLETE THIS FORM:

1. Complete Sections One, Two, Three and Four.
2. Complete and sign the declaration at the end of Section Four.
3. Ask your GP to complete Section Five.
4. You do not usually need an appointment for this. If your doctor needs to see you, they will let you know. Your doctor may charge a fee for this service.
5. Ask your GP to return the form to you when completed.

All information is held in accordance with SurrogacyUK's GDPR policy.

SurrogacyUK will not necessarily refuse your application based on current or previous health problems.

This form will also assist us in providing additional support to you throughout your surrogacy journey (if required).

If you need any help completing this form, please email ip.applications@surrogacyuk.org

When the form has been completed by the applicant AND the GP return to SurrogacyUK.

Please scan/photograph this form and email it to ip.applications@surrogacyuk.org

SECTION ONE – CONTACT DETAILS

Applicant full name:

Applicant date of birth:

Applicant address:

GP name:

Surgery name and address:

Surgery telephone number:

SECTION TWO – HEALTH

NOTE: If you answer yes to any of the following questions please give full details in the comments section below.

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| Do you have any medical conditions at the moment? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Have you had any medical conditions in the past? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have any mental health issues at the moment? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Have you had any mental health issues in the past? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Do you have any genetic/hereditary conditions?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever been refused insurance because of your health?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had any exclusions applied to an insurance policy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever taken recreational drugs?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you taking any medication?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please detail below:

Medication Name	Reason for Medication	Dosage	Length of time taking medication

Comments:

Comments:

SECTION THREE – FERTILITY

NOTE: If you answer yes to any of the following questions please give full details in the comments section below.

Have you experienced any issues with your fertility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you had any fertility testing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you had a semen analysis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you ever had fertility treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you been told you are unable to carry a pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you been told IVF for yourself is not a viable option?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>
Have you been advised against having fertility treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	n/a <input type="checkbox"/>

Comments:

Comments:

SECTION FOUR - SOCIAL

NOTE: If you answer yes to any of the following questions please give full details in the comments section below.

Do any existing children live with someone other than you?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	n/a	<input type="checkbox"/>
Have Children & Family Services had contact with your family?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Has there ever been any domestic violence in your household?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		

Comments:

STATEMENT OF DECLARATION

We will use the information that you and your GP give on this form to help make a decision in regard to your application to join SurrogacyUK as an intended parent.

I understand that this is how SurrogacyUK will use this information.

I consent to my GP sharing my health information with SurrogacyUK for the purpose of assessing my application to join SurrogacyUK as an intended parent.

I declare that to the best of my knowledge the answers given to the questions above are full and correct. I agree to notify SurrogacyUK of any significant changes to my health.

Signed:	<input type="text"/>
Print name:	<input type="text"/>
Date:	<input type="text"/>

EXPLANATORY NOTES FOR THE GENERAL PRACTITIONER

The applicant is applying join SurrogacyUK as an intended parent.

SurrogacyUK undertakes reasonable checks to ensure that intended parents are fit and well enough to undertake a surrogacy journey, and that they are eligible join SurrogacyUK in line with its admissions policy.

This report helps us to gain an understanding of the applicant's:

- Physical, mental and emotional wellbeing.
- Fertility and obstetric history (if applicable).
- Social history.

In addition to this report SurrogacyUK ensures that the applicant will have undertaken a criminal background check (DBS), and an interview with one of our advisors.

To help us reach a decision, please complete Section Five of this form. The applicant has consented to this and understands we will use this information to assess their suitability to join SurrogacyUK as an intended parent.

No physical examination is required. SurrogacyUK only requires factual information from the applicant's records.

If there is a charge for this information, please inform the applicant.

Should you have any queries please contact ip.applications@surrogacyuk.org

Thank you for your help.

WHEN COMPLETE PLEASE RETURN THE FORM TO THE APPLICANT

SECTION FIVE – GP INFORMATION

Do you have the applicant’s medical records from birth?

Yes No

Are the applicant’s records for a continuous period?

Yes No

If no, please state what date the records start from, and detail any gaps in the records:

Does the applicant have any medical conditions or medical history that you feel are relevant to their application to join SurrogacyUK or undertake a surrogacy journey as an intended parent?

Comments:

Does the applicant take any regular medications?

Yes No

Please detail below:

Medication Name	Reason for Medication	Dosage	Length of time taking medication

NOTE: If you answer yes to any of the following questions, please give full details in the comments section below.

Does the applicant have any history of infertility?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Has the applicant undertaken their own IVF?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>

Comments: **Please detail history of infertility and fertility treatments already undertaken**

Does the applicant have history of drug/alcohol misuse?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Does the applicant smoke?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>

Comments:

Does the applicant have any past psychiatric history such as low mood, anxiety, depression etc? In your judgement, do you feel it will affect their surrogacy journey as an intended parent?

Comments:

Has the applicant undertaken any sort of counselling?

Comments:

To the best of your knowledge, are there any social concerns relating to the applicant or any existing children that would be relevant eg history of domestic violence, Children & Family Services involvement, CAF procedures etc?

Comments:

Do you have any other concerns regarding the applicant's suitability to join SurrogacyUK and undertake a surrogacy journey as an intended parent?

Comments:

GP VERIFICATION

Official Stamp:

GP Name:

Signature:

GMC Ref No:

Date:

PAYMENT DETAILS

Paid by Applicant:

Amount to be charged:

BACS Details: