



# Giving Hope

FERTILITY ASSISTANCE FUND

162-2025 Corydon Avenue, Suite 136  
Winnipeg, Manitoba  
R3P 0N5

## PHYSICIAN FORM

Patient Name:	_____
Date of Birth(m/d/y):	_____
Chart No.:	_____

1. Has either the Applicant or Co-Applicant (if any) previously undergone a sterilization procedure?

YES  NO

2. Has the Applicant been trying to conceive for a minimum of 24 months?

YES  NO

If not, has the Applicant been diagnosed with a condition or abnormality that would make natural conception impossible or extremely unlikely.

YES  NO

Details (if any):

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3. Does the Applicant have at least a 20% expectation for success with an IVF cycle?

YES  NO

4. Is the Applicant in good mental and physical health?

YES  NO

Comments (if any):

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5. Is the Co-Applicant in good mental and physical health?

YES  NO

Comments (if any):

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