Fertility Treatment Follow-up ©2007 Clear Passage Therapies, Inc.

Please answer all questions to the best of your ability

Patient Contact Information*			Today's Date:	
Name:			Date of birth:	
Address:	City:		State:	Zip:
Contact phone:	Contact email:			
Last date of service:	# of therapy hrs:		Clinic location:	

Post-therapy outcomes (Please complete this section to advise us of any pregnancy and/or other result)

Pregnancy:

I am now pregnant	Due Date:	Comment:	
Became pregnant	# of pregnancies:	Date(s):	
Delivered	Name(s), birth date(s):		
Miscarried	Dates:	Ectopic	Dates:
Chemical (HCG but no heartbeat)	Dates:		I have not yet become pregnant
Became menopausal	Approx. Date:		No longer trying to become pregnant

IVF after therapy:	Started cycle/medications (date):	Transfer date:	N/A
Egg type: Fresh / Non-Donor / Frozen / Donor	Results: Pregnancy / Miscarriage	Chemical pregnancy (HCG but no heartbeat) / Ectopic / Did not become pregnant	
Details/comments:			
2nd IVF after therapy:	Started cycle/medications (date):	Transfer date:	N/A
Egg type: Fresh / Non-Donor / Frozen / Donor	Results: Pregnancy / Miscarriage	Chemical pregnancy (HCG but no heartbeat) / Ectopic / Did not become pregnant	
Details/comments:			

Additional procedures (medical, drug, surgery, natural): N/A

Tube(s) cleared: Left Right N/A Diagnosed by: HSG Laparoscopy Laparotomy

Hydrosalpinx cleared: Left Right N/A Diagnosed by: HSG Laparoscopy Laparotomy

Details/comments:

Sexual Function: Since therapy, I note an increase in:

Desire Arousal Lubrication Orgasm Satisfaction Intensity Frequency Duration

Details/comments:

Pain: Since therapy, I note an decrease in: Intensity Frequency Duration

Details/comments:

***Contact:**	**CPT always keeps your identity confidential. Be assured, even if you note interest in speaking with potential patients or the media, we will contact you for specific occurrence authorization before sharing any identifying information.**

May we call on you to share your experience with potential patients? Yes No

May we call on you to share your experience with the media? Yes No

Please note your preferred method of contact (Phone # / fax # / email address):

Please use the second page to note your story, comments and/or questions. Though we may use your comments anonymously, we always keep your identity confidential. You may print this response for your records. When completing online, please click "Submit Info to Clear Passage". When completing on hard copy, please send via fax (352-336-9980) or postal mail:

3600 NW 43rd Street, Ste. A1
Gainesville, FL 32606

Please feel free to contact us anytime for any reason by mail, email (info@clearpassage.com), phone (352-336-1433) or fax. Thank you for your feedback!

-Clear Passage Therapies

Thank you again for your response. We look forward to hearing from you!

-Your Clear Passage Therapies Team