CHECK LIST FOR PRE-BIRTH DOCUMENT PREPARATION

Intended Parent 1:

- ❑ Male
- ❑ Female

Name:_____

Address:_____

Phone: _____

County of Residence: _____

Country of Residence: _____

Date of Birth: _____ Age_____

Intended Parent 2:

- ❑ Male
- ❑ Female

Name:_____

Address:_____

Phone: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Are IPs represented by an Attorney? _____yes _____ no

If yes, Name:_____

Address:_____

Phone: _____

Emily M. Hete, Esq. 1000 S. Cleveland-Massillon Road, Suite 105 Akron, OH 44333
330-666-6400 ehete@henshawhete.com

Are the Intended Parents Married? _____yes _____ no

If yes, is the marriage recognized in the State of Ohio? _____yes _____ no

If no, are they engaged to married? _____yes _____ no

If yes, when? _____

Carrier:

Name:_____

Address:_____

Phone: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Carrier's Spouse/Partner:

- Male
- Female

Name:_____

Address:_____

Phone: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Is Carrier represented by an Attorney? _____yes _____ no

If yes, Name:_____

Address:_____

Phone: _____

Is the Carrier Married? _____yes _____ no

If yes, is the marriage recognized in the State of Ohio? _____yes _____ no

If no, is the Carrier engaged to be married? _____yes _____ no

If yes, when? _____

Is the Carrier related to the Intended Parents? _____yes _____ no

If yes, how? _____

Does Carrier have any children of her own? _____ yes _____ no
If yes, how many children and their ages _____
_____

Does Carrier's Husband have any children of his own? _____ yes _____ no
If yes, how many children and their ages _____
_____

Is there a Surrogacy Contract between Carrier & IPs? _____ yes _____ no

If yes, please provide a copy to Attorney Hete

(330-666-1532 fax) or (ehete@henshawhete.com) or mail

What is the date the Surrogacy Contract was signed? _____

Whose egg was used: _____
Intended mother/carrier/anonymous egg donor/embryo donor

Whose sperm was used: _____
Intended father/donor sperm/embryo donor

****If you are using donor eggs or donor sperm, please obtain a copy of the Donor Consent Form from the facility in which you are obtaining the eggs/sperm. Provide a copy to Attorney Hete as soon as possible.*****

Did the IPs use a Fertility Clinic/Fertility Program? _____ Yes _____ no

If yes:

Name _____

Address _____

Phone _____

Name of Physician you worked with _____

Name of Embryologist (if not Physician) _____

Name of Nurse (if applicable) _____

When did you engage the services of the program? _____

Do you have a contract with the program _____ yes _____ no

If yes, please provide a copy of the contract to Attorney Hete.

Did the above named clinic/program create the embryos used for this surrogate pregnancy? _____ Yes _____ no

If yes, please provide the name of the Physician, Embryologist and any nurse who has knowledge of the creation of embryos, including egg retrieval, sperm retrieval and IVF procedures.

Name (Physician) _____

Name (Embryologist) _____

Name (Nurse) _____

Name (other professional) _____

If NO: please provide the information relevant to the clinic who created the embryos or the origin of the embryos:

Name _____

Address _____

Phone _____

Name of Physician you worked with _____

Name of Embryologist (if not Physician) _____

If you had an embryo transfer or IVF transfer:

Who performed the transfer procedure (provide all names if more than one)

Name _____

Address _____

Phone _____

Name of Physician you worked with _____

How many embryos were transferred _____

Date of Transfer _____

If you became pregnant through Artificial Insemination:

Home insemination _____ yes _____ no

Physician insemination _____ yes _____ no

Date of Insemination _____

If you had the Physician perform the insemination:

Name of Physician: _____

Address _____

Phone _____

Date of Insemination_____

The due date is _____

The Carrier is pregnant with a _____ pregnancy.
Singleton/twin/triplet, etc.

The child will be delivered at _____ hospital

Hospital

Name: _____

Address :_____

Phone: _____

County: _____

OBGYN

Name of Physician who has provided pre-natal care _____

Name of Group/Clinic Physician works with _____

Address _____

Phone _____

Will this physician do the delivery? _____Yes _____ No

*** PLEASE PROVIDE A COPY OF YOUR SURROGACY CONTRACT IF NOT PREPARED/REVIEWED BY ATTORNEY HETE ***

Services for Pre/Post Birth Orders are billed
at an hourly rate of **$200.00 per hour**.

Retainer fees vary based upon jurisdiction.
[$2,500 for Summit County]
[$3,500 for other Counties]
[$5,000 for International Cases]

Make checks Payable to: Emily M. Hete, Esq.

Please complete this form and **return it**
via FAX, MAIL, or EMAIL
to Attorney Emily M. Hete
330-666-1532 fax
ehete@henshawhete.com

Questions? Call 330-666-6400

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