DMBA

INFERTILITY TREATMENT SUMMARY

Patient name: _____ Birth date: _____ DMBA ID: _____

DATE	PROCEDURE*	CYCLE #	IVF CENTER	STIMULATION # OF AMPS	PEAK E2	# EGGS RETRIEVED	# EGGS FERTILIZED	EMBRYO QUALITY	# EMBRYOS TRANSFERRED	# EMBRYOS CRYO	BETA HCG

*** Key for procedure type:**

1. IVF/Fresh Cycle
2. IVF/FET
3. IVF attempted, no eggs retrieved
4. FSH/IUI
5. CC/IUI
6. IVF with ICSI
7. IVF attempted no sperm available
8. Canceled cycle

- You may use additional copies of this form if necessary.
- Fax the completed form(s) to 801-578-5916 or 800-777-5113.
- For more information, call Member Services at 801-578-5600 or 800-777-3622.