R A N D Y S . M O R R I S M . D .
B O A R D C E R T I F I E D R E P R O D U C T I V E E N D O C R I N O L O G Y
A N D I N F E R T I L I T Y

Mental Health Evaluation for Intended Parents

Name of intended parent/parents: _____

Date of birth/births: _____

I certify that I am a licensed psychiatrist or psychologist. I hereby confirm that I have performed a mental health evaluation on _____ and_____.

Date of exam:_____

In my opinion, (please check the appropriate box)

☐ There are no mental health issues that would preclude this person/the couple from undergoing an IVF cycle with a gestational carrier

☐ I do **not** recommend that this individual/couple undergoing an IVF cycle with a gestiational carrier

_____

Signature of evaluator Date

636 Raymond Drive • Suite 303 • Naperville IL 60563
Phone: (630) 357-6540 • Fax: (630) 357-6435

900 North Michigan Ave. • 15th Floor • Chicago IL 60611
Phone: (312) 440-5055 • Fax: (630) 357-6435