Confirmation of infertility by specialists

I. Basic information

Name of the person undergoing treatment.

Name _____ ID-No. _____

II. Information on infertility

Date of diagnosis: _____

When was medical advice first sought in respect of infertility? _____

Description of infertility (ICD)

_____

_____

_____

Is there any relevant medical history? ☐ Yes ☐ No

If yes, please provide more details:

_____

_____

_____

_____ _____

Place and date Signature of doctor

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