PINK STORK
FERTILITY ASSISTANCE PROGRAM

More than 150,000 people of reproductive age are diagnosed with cancer each year. For cancer survivors, fertility preservation can be a distressing struggle. Insurance providers often don't cover the cost of expensive treatment and patients can be faced with starting cancer treatment right away which may impact their fertility. The Pink Angels of the Memorial Foundation helps bridge this gap by offering access to discounted fertility preservation services and financial aid to patients diagnosed with breast cancer.

To qualify, patient must:

- Be female
- Be US citizen or permanent resident
- Be a patient of, and receive treatment at Memorial Breast Cancer Center.
- Have a diagnosis of breast cancer
- Approved prior to cancer treatment
- Not have had recent chemotherapy treatment within prior six months
- Have oncologist and reproductive endocrinologist determine that fertility preservation treatment is medically appropriate.

Up to $2,500 will be made available directly to the chosen IVF Center upon approval.
*If patient is approved for the Pink Stork Fertility Assistance and does chooses not to complete the Ovum retrieval any funding must be returned to the Pink Angels Fund c/o the Memorial Foundation.

The Pink Angels of the Memorial Foundation are committed to securing funds and awareness to support the Breast Cancer Center at Memorial Cancer Institute and to better serve patients and their families. For more information regarding opportunities to support the Pink Angels and the Breast Cancer center at memorial Cancer Institute please contact us at PinkAngels@mhs.net.

PINK STORK
FERTILITY ASSISTANCE PROGRAM
ONCOLOGIST AND REPRODUCTIVE ENDOCRONOLOGIST
PHYSICIAN REFERRAL FORM

Please complete all the fields in the following form and keep a copy for your records. Incomplete applications will not be accepted. Applications will be processed within 14 days of submission.

PATIENT INFORMATION

_____ _____ _____ _____
Last Name First Name Middle DOB

_____ _____ _____
Primary Phone E-Mail Address

PHYSICIAN INFORMATION

Oncologist

_____ _____ _____ _____
Last Name First Name Title DEA/NPI#

_____ _____
Clinic/Hospital Street Address

_____ _____ _____ _____
City State Zip E-Mail

_____ _____
Phone Fax

TREATMENT INFORMATION

_____ _____
Diagnosis Date of Diagnosis

TREATMENT PLAN (check all that apply)
_____Surgery _____Radiation _____Chemotherapy Other (please explain)

TREATMENT TIMELINE

_____ _____
Estimated Start Date Date Range of Treatment

Does the treatment plan described above present a risk of infertility to the patient? ___Yes ___No
Would you recommend this patient as a viable candidate for IVF/Oocyte Retrieval? ___Yes ___No
Has the patient been fully informed with all medical requirements, procedures and risks involved with IVF?_Yes_No

I have discussed with the patient the risks, side effects and other aspects of her treatment options. I certify that in my medical judgement there is no reason that the above-names patient should not undergo ovarian stimulation and oocyte retrieval as prescribed by a reproductive endocrinologist for the purposes of fertility preservation. Neither the Memorial Foundation nor the Pink Angels Organization are medical providers, and I acknowledge that neither the Memorial Foundation and Pink Angels Organization shall be liable for any aspect of the treatment of the patient I have referred as a candidate for financial assistance as part of the Pink Angels Fertility Assistance Program (AKA the Pink Stork Fund)

Oncologist Signature_____ Date_____

PATIENT INFORMATION

_____ _____ _____ _____
Last Name First Name Middle DOB

REPRODUCITVE ENDOCRONOLOGIST

_____ _____ _____ _____
Last Name First Name Title DEA/NPI#

_____ _____
Clinic/Hospital Street Address

_____ _____ _____ _____
City State Zip E-Mail

_____ _____
Phone Fax

TREATMENT PLAN

____Egg Retrieval and Freezing ___Embryo Freezing

TREATMENT TIMELINE

_____ _____
Estimated Start Date Date Range of Treatment

Does the patient treatment plan present a risk of infertility to the patient? ___Yes ___No
Would you recommend this patient as a viable candidate for IVF/Oocyte retrieval? ___Yes ___No
Has the patient been fully informed with all medical requirements, procedures and risks involved with IVF? _Yes_No

I have discussed with the patient the risks, side effects and other aspects of her treatment options. I certify that in my medical judgement there is no reason that the above-names patient should not undergo ovarian stimulation and oocyte retrieval as prescribed by a reproductive endocrinologist for the purposes of fertility preservation. Neither the Memorial Foundation nor the Pink Angels Organization are medical providers, and I acknowledge that neither the Memorial Foundation and Pink Angels Organization shall be liable for any aspect of the treatment of the patient I have referred as a candidate for financial assistance as part of the Pink Angels Fertility Assistance Program (AKA the Pink Stork Fund)

IVF Physician Signature_____ Date_____

SOCIAL WORKER REFERRAL

_____ _____ _____ _____
Last Name First Name Title Certification

_____ _____
Clinic/Hospital Street Address

_____ _____ _____ _____
City State Zip E-Mail

_____ _____
Phone Fax

Does the patient treatment plan present a risk of infertility to the patient? ___Yes ___No
Would you recommend this patient as a viable candidate for IVF/Oocyte Retrieval Pick Up? ___Yes ___No
Has the patient been fully informed with and aware of all medical requirements, procedures and risks involved with IVF?_Yes_No

I have discussed with the patient the risks, side effects and other aspects of her treatment options. I certify that in my medical judgement there is no reason that the above-names patient should not undergo ovarian stimulation and oocyte retrieval as prescribed by a reproductive endocrinologist for the purposes of fertility preservation. Neither the Memorial Foundation nor the Pink Angels Organization are medical providers, and I acknowledge that neither the Memorial Foundation and Pink Angels Organization shall be liable for any aspect of the treatment of the patient I have referred as a candidate for financial assistance as part of the Pink Angels Fertility Assistance Program (AKA the Pink Stork Fund)

Social Worker Signature _____ Date_____