Male/Female Choice Gender Selection Services

Patient Name_____

Spouse's Name _____

Date of Service_____

Number of Children_____

Ages and Genders of each Child_____

We desire to opt for gender selection in hopes of a:

_____Boy _____ please initial

_____Girl _____ please initial

Our intention for gender selection is:

_____Family Balancing

_____Avoidance of Chromosomal Defect

_____Other: please state reason_____

We understand there is no guarantee with this procedure._____ please initial

Patient Signature_____ Date _____