Schedule C

AID RECEIVING COUPLE

(Must be completed by the person performing the insemination)

*Patient No._____

	HUSBAND/PARTNER	WIFE
Occupation		
Age		
Race		
Religion		
Height		
Weight		
Colour: Hair Eyes Complexion		
Hair: e.g. straight, curly, etc		
Cause of infertility		
Blood-group ABO Rhesus		
Genetic abnormalities example Tay-Sachs or Thalassaemia (only wife)		

*NB. Patients name should not be mentioned

Signed: _____

Person who performed the insemination

Date	IF	Vag	CX	IU	Sem. No	Pregnant	V	T	M	VP	M