Caring for women involved in Surrogacy guideline

1. Aim/Purpose of this Guideline

This guideline has been developed to provide the multi-agency team with clear guidance to enable appropriate care for surrogate women in pregnancy but to appreciate the position of the commissioning (intended) parents and include them in the care if appropriate.

2. The Guidance

Definitions

The surrogacy Arrangements Act 1985 chapter 45 pages 1 define a surrogate mother as:

A woman who carries a child in pursuance of an arrangement

- Made before she is carrying the child and
- Made with a view that any child carried in pursuance of it being handed over to, and parental rights being exercised (so far as practicable) by, another person or persons.

There are two types of surrogacy

1) Traditional or straight surrogacy. This is where the surrogate uses her own egg, which is fertilised with the intended or commissioning father’s sperm; this may be done by self-insemination using a syringe or done in an infertility clinic.

2) Gestational, full or host surrogacy. The surrogate carries the commissioning parent’s genetic child conceived through in-vitro fertilization at an infertility clinic.

Legal aspects of surrogacy

Surrogacy is not prohibited by law however surrogacy through commercial arrangement is illegal (in accordance with section 2 Surrogacy arrangements act 1985) and therefore it is an offence for an individual or agency to act on a profit-making basis to organise or facilitate a surrogacy arrangement for another person.

Any persons or organisations that organise or facilitate a surrogacy arrangement must do so on a non-commercial basis.

Surrogate mothers can however receive reasonable expenses from the intended parents, such as for maternity clothing, insemination and IVF costs and costs of travelling to and from hospital. More examples can be found in “Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation 1998” available on the Department of Health Website.

Staff should be alert to any third parties (ie parties outside the Surrogate mother and Intended Parents) who may be acting illegally on a profit making basis. Should staff become suspicious that the parties are involved in a commercial arrangement, they should contact the Lead Safeguarding Midwife for Children, for further advice and guidance.

In the United Kingdom the birth mother is the legal mother irrespective of the conception method and genetic make-up of the baby. The Surrogate’s husband if married is considered the legal father of the child unless he can prove he did not consent to the surrogacy process.
The Courts have held that a surrogacy arrangement is not a legally binding contract and therefore an arrangement between the Surrogate Mother and the commissioning (intended) parents is not enforceable. Either party are therefore free to change their mind at any time.

The Parental Orders (Human Fertilisation and Embryology) Regulations 1994 came into effect in November 1994 which brought into effect section 30 of the Human Fertilisation and Embryology Act 1990 also known as Parental Orders. This allows commissioning (intended) parents the opportunity to become the child’s legal parents. The following criteria must be met in order to apply for a Parental Order issued by the Family Proceedings Court in the applicant’s home area:

- Over 18
- Commissioning parent must be resident in UK
- At least one of the applicants must be genetically related to the child
- Apply after 6 weeks of birth and before 6 months
- The surrogate parents must consent to the making of the order
- No money other than expenses must have been paid in respect of the surrogacy arrangement
- The child must reside with the commissioning (intended) parent

Under English law, once the Parental Order is granted, the commissioning (intended) parents will receive a new birth certificate stating that they are the legal parents of the child (Surrogacy UK 2007). Further information for patients and staff can be found at www.hfea.gov.uk

General guidance
Health care professionals have a legal duty of care to the surrogate mother and the baby once born. The wishes of the surrogate are paramount and the commissioning (intended) parents will only become involved with her direct consent.

The multi-professional team should be non-judgmental and encourage the surrogate to be open and honest about the arrangements to ensure a good relationship based on trust. Information should only be shared by health care professionals on a need to know basis and only then with the consent of the surrogate.

Record keeping: details of the surrogacy agreement should only be documented in the health care records if the surrogate consents.

The Head of Midwifery should also be informed if the commissioning (intended) mother requests to stay in hospital to arrange support and guidance for parenting skills and care of the new born if required.

Mental capacity of the Surrogate Mother to make decisions
Should staff have concerns regarding the mental capacity of the Surrogate Mother to make decisions about her pregnancy or labour and birth, a formal assessment of capacity should be performed, staff are advised to follow the Trusts consent policy. In the event that the Surrogate Mother lacks capacity to make a particular decision, treatment should be given having regard for the best interests of the Surrogate Mother. However, staff are advised to consult the Trusts lead on the Mental Capacity Act prior to administering treatment in such circumstances.
Pre-birth

Antenatal screening
Where treatment has been provided in a licensed clinic, the eggs and the sperm to be used will be tested for HIV, hepatitis and other transmittable diseases. However with self-insemination, there will be a risk of transmission of infection to the Surrogate Mother. It is therefore important that the Surrogate Mother is counselled of this risk and offered testing accordingly. The guidance from the British Medical association also recommends that the intended Father is tested prior to insemination. (Considering Surrogacy? Your questions answered) BMA 2007
Should the Surrogate Mother be identified as having a transmittable disease, staff are prohibited from sharing this information with the Commissioning (intended) parents or other third parties without the consent of the Surrogate Mother. To do so would be a breach of patient confidentiality. The Surrogate Mother should however be counselled of the risks of the transmission of infection to the child and any recommended steps at birth to minimise the risk of transmission, in the usual way.
The Surrogate Mother should be offered all applicable ante natal screening tests for abnormalities. Staff should only perform tests that the Surrogate Mother has consented to. The Commissioning (intended) parents have no authority to demand testing that the Surrogate Mother does not consent to. Should an abnormality be identified in the unborn child, staff should not share this information with the commissioning (intended) parents or other third party without the consent of the Surrogate Mother.

Antenatal care
It is important to recognise that the Trusts duty of care is to the Surrogate Mother. The Trust owes no duty to the Commissioning (intended) parents. All applicable antenatal care should be provided to the Surrogate Mother in the usual way. The Commissioning (intended) parents can be involved in the process provided that the Surrogate Mother consents to this. The Trust should facilitate this so far as is practical.
The Surrogate Mother has the right to make all decisions relating to her ante natal care. It is important to remember that the child is not recognised as a “person” until the birth and therefore the rights of the mother should take precedence over the interests of the unborn child. No one else can make decisions on her behalf.
The intended parents will often attend antenatal appointments with the surrogate mother and good practice will involve obtaining the GP and health visitor details and for community midwife to make contact with health visitor. Due to the legal complexities, health professionals should advise women involved in surrogacy arrangements that they may wish to seek the expert advice of a lawyer (DOH, 2008)

Birth planning
The Surrogate Mother and the commissioning (intended) parents will often sign up to a written agreement which will usually set out the preferred method of birth, who will be present for the birth, who will hold the baby after birth and who will make decisions about the child’s welfare etc. Staff should be aware that these agreements are not legally binding and should be used as a guide only.
Where a pre-prepared agreement is not in place, staff should work with the Surrogate and commissioning (intended) parents where possible (so long as the Surrogate Mother consents to their involvement) to develop an agreed birth plan. Whilst it is clearly beneficial
for these discussions to take place in partnership with the commissioning (intended) parents, final decisions about delivery must be made by the Surrogate Mother.
Where a birth plan is completed with the involvement of the community midwife, a copy of this should be filed in the Surrogate Mothers hand held notes, Medical notes and delivery Suite Alert Folder. The Midwifery Inpatient Matron should also be informed by the community midwife.

Confidentiality
The Surrogate Mothers confidentiality should be respected at all times. This means that no information about the Surrogate Mother or the unborn child should be shared with the Commissioning (intended) parents or any other third party without her consent.

Care of the Surrogate Mother in the post natal period
Routine postnatal care should be provided to the Surrogate Mother. Particular care should be paid to her psychological state and additional support offered. Additional postnatal visits may be beneficial and should be decided on an individual basis.
The legal guardianship of the baby remains with the surrogate mother, until the Court has granted a Parental Order. This means the consent for any treatment, medication or screening of the baby must be obtained from the Surrogate Mother, even if the baby is handed over at birth. The baby cannot be removed from the hospital by the commissioning (intended) parents without the Surrogate Mothers consent.
If the Surrogate Mother requires continued admission to hospital for medical reasons but the baby does not require admission, the Surrogate Mother may wish to delegate responsibility for care of the baby over to the commissioning (intended) parents.
Parental responsibility in the context of who can make decisions and give consent regarding the baby’s treatment and care must be explained to the Surrogate Mother and intended parents by a registered Midwife, Co-ordinator or Matron.

A record of this discussion must be recorded and filled in the Surrogate Mothers medical notes, the baby’s medical record and a copy given to the commissioning (intended) parents using the following forms and checklist: ( appendix 3)

Forms: Midwifery Documents – Surrogacy - Delegate Responsibility to intended parents. (RCHT/M/S/DR 1)

Midwifery Documents – Surrogacy – Consent to remove baby from hospital.
(RCHT/M/S/CTL 1)

Surrogacy postnatal check list

The Surrogate Mother will require a community Midwife to visit in the usual way. When discharged from hospital this should be communicated to the community midwife, GP and health visitor in the normal way. Whilst there is no conclusive data on the incidence of post natal depression in surrogate mothers, Reame (1990) suggested that 75% experienced a degree of post natal depression for 2-6 weeks following the birth. For this reason, access to a community midwife should be encouraged for 28 days.

Care of the baby in the post natal period
The commissioning (intended) parents have no legal rights over the baby until the baby is adopted. Where possible decisions about the baby’s treatment should be made jointly, by the Surrogate Mother and commissioning (intended) parents in conjunction with health
care professionals. In most cases the Surrogate Mother will hand over responsibility to the commissioning (intended) parents on an informal basis, at birth. However it must be noted that the Surrogate Mother remains legally responsible for the baby until the parental order is granted. Should the baby require admission and on-going treatment the commissioning (intended) mother should not be admitted as a patient of the Trust. If the Surrogate Mother requests that the commissioning (intended) Mother be permitted to stay with her until the baby is discharged, this should be accommodated and recorded in the notes.

Following the birth where the surrogate has delegated responsibility for the child to the commissioning (intended) parents, the commissioning mother should be accommodated where ever possible in a side room on the postnatal ward. Parenting advice and support will then be provided to the intended mother until the baby is discharged. This arrangement must be recorded in the Surrogate Mothers notes and the baby’s notes, stating that this is the request of the surrogate mother. The commissioning (intended) mother’s presence on the ward should be recorded in the ward diary.

The commissioning (intended) parents and the baby will require a community midwife visit and the baby’s discharge should be communicated to the community midwife, GP and Health visitor in the normal way. This may be an out of area discharge and it is vital that during the antenatal period the commissioning (intended) parents, address, telephone number, local hospital and GP contact details are recorded in the antenatal records. The immediate post natal period is a time of great emotional upheaval which may be compounded in a surrogacy arrangement. Great sensitivity is required in handling both the surrogate and intended parents. Where there is conflict the midwife must focus her care on the surrogate and the baby.

How do the commissioning (intended) parents become the legal parents of the baby?

Heterosexual couples
In order for the commissioning (intended) parents to become the legal parents of the baby, they must either apply to adopt the baby or apply for a parental order. This is true, even if the Commissioning (intended) parents are the genetic parents of the baby.
It is important to remember that whilst the Surrogate Mother and/or the commissioning (intended) parents may wish responsibility for the child to pass to the intended parents at birth, the Surrogate Mother remains legally responsible for the baby until the parental order has been granted or the baby has been legally adopted by the commissioning parents. The commissioning parents have no legal rights over the baby until this time.

Same sex couples
The civil partnership Act 2004 set up a framework to allow same sex couples to achieve legal recognition of their relationship. Civil partners may apply to adopt the child or apply for a residence order. Currently civil partners cannot apply for a parental order.

What happens if there is a dispute between the commissioning (intended) and the Surrogate Mother?
The Trust should attempt to work with the Surrogate Mother and commissioning (intended) parents at all times. Should a dispute arise, the Surrogate Mothers wishes should be respected at all times and staff may consider contacting the Lead Midwife for Safeguarding children for future advice and Guidance.
If the commissioning (intended) parents attempt to remove the baby from the Trust premises against the Surrogate Mothers wishes, staff should consider informing the police.

**What if the commissioning (intended) parents change their mind?**
If the commissioning (intended) parents change their minds about taking the child the Surrogate Mother (and her partner if she has one) will be legally responsible for the child. In the event that the Surrogate Mother also refuses to take on responsibility, social care should be contacted in the usual way.

**What if the Surrogate Mother changes her mind?**
If the Surrogate Mother changes her mind and wishes to keep the baby, the Trust must respect her wishes. In this situation the courts will usually allow her to keep the baby. If there is a disagreement between the parties, the Lead Midwife for safeguarding children should be contacted.

**What if the child becomes ill and needs treatment?**
Where possible decisions about the child’s treatment should be made jointly, by the surrogate Mother and the commissioning (intended) parents and in conjunction with health professionals.
In most circumstances the Surrogate Mother will hand over responsibility to the commissioning (intended) parents on an informal basis, at birth. However, the Surrogate Mother remains legally responsible for the baby until a parental order has been granted of the baby has been legally adopted by the commissioning (intended) parents.
The BMA, in their “Considering Surrogacy” guidance, state that provided the baby has been “passed” to the commissioning (intended) parents by the Surrogate Mother; responsibility for decision making should pass to them.
Therefor where a Surrogate Mother informs staff that she has handed over responsibility for the baby to the commissioning (intended) parents, staff should consult with the commissioning (intended) parents in respect of decision making and seek their consent to procedure accordingly.
Staff should request that the Surrogate Mother records in writing that she is delegating responsibility to the intended parents. Whilst the Surrogate Mather cannot surrender or transfer any part of her responsibility to the commissioning (intended) parents without the permission of the court, she can arrange for some or all of it be met by one or more persons acting on her behalf (ie the intended parents) this arrangement is not however legally binding.
As a matter of law the Surrogate Mother has parental responsibility at birth and therefore, has the legal right to consent/refuse treatment on behalf of her child. This is the position until the commissioning (intended) parents have a obtained a Parental Order/adoption proceedings are finalise.

**Registering of a Surrogate Child**
The law requires a birth to be registered within 6 weeks.

If the Surrogate Mother is married, she and her husband will be named on the birth certificate as the parents. If the husband writes a letter stating that he did not give permission for the arrangement, the intended father can be named as the Father.

If the Surrogate Mother is unmarried and the intended Father is present when the birth is registered, he may be named as the Father on the birth certificate and thus obtain parental responsibility. This is true whether the birth came about by self-insemination or by IVF at a
licensed clinic. The commissioning (intended) parents will need to obtain a parental order to become the legal parents. The birth can then be re-registered to show the commissioning (intended) parents as the parents of the child.

**Source of advice and support**
- Lead Midwife for Safeguarding children
- Supervisor of Midwives
- (LSA guidance to support midwives in caring for women involved in surrogacy)
- Senior Midwife/Matron
- Line Manger
- Legal Department

### 3. Monitoring compliance and effectiveness

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<tr>
<th>Element to be monitored</th>
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<tbody>
<tr>
<td>Lead</td>
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<tr>
<td>Frequency</td>
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<td>Reporting arrangements</td>
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<td>Change in practice and lessons to be shared</td>
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### 4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

**4.2. Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Guidance for the care of women involved in surrogacy arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7TH July 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>7th July 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>7th July 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Treena Figg. Inpatient Matron for Maternity. Women’s Children and Sexual Health</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252143</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline has been developed to provide the multi-agency team with clear guidance to enable appropriate care for surrogate women in pregnancy but to appreciate the position of the commissioning (intended) parents and include them in the care if appropriate.</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Surrogacy host parent surrogate</td>
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<td>Target Audience</td>
<td>RCHT PCH CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Date revised:</td>
<td>New Guideline</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Guideline</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guideline Group Obs and Gynae Directorate Divisional Board for noting</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Head of Midwifery</td>
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<tr>
<td>Name and Post Title of additional signatories</td>
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</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet Intranet Only</td>
</tr>
</tbody>
</table>
### References


4) COTS Surrogacy in the UK www.surrogacy.org.uk

5) www.hfea.gov.uk

6) Department of Heath, 2008: emaildhmail@gsi.gov.uk

7) The adoption and children Act 20002

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>7th July 2016</td>
<td>V.1</td>
<td>New Guideline</td>
<td>Treena Figg. Inpatient Matron for Maternity</td>
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Caring for women involved in surrogacy
All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
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<tbody>
<tr>
<td>Obs &amp; Gynae Directorate</td>
<td>New</td>
</tr>
</tbody>
</table>

Name of individual completing assessment: Treena Figg

Telephone: 01872 252143

1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at?
To provide the multi-agency team with clear guidance to enable appropriate care for surrogate women in pregnancy but to appreciate the position of the commissioning (intended) parents and include them in the care if appropriate.

2. Policy Objectives*

3. Policy – intended Outcomes*

4. *How will you measure the outcome?
Compliance Monitoring Tool

5. Who is intended to benefit from the policy?
All women

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
No

b) If yes, have these *groups been consulted?
N/A

C). Please list any groups who have been consulted about this procedure.
N/A

7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
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</table>

Caring for women involved in surrogacy
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<table>
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</thead>
<tbody>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Disability</strong> - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td>X</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. [ ] Yes [ ] No [ ]

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director

Date of completion and submission

Names and signatures of members carrying out the Screening Assessment

1.  

2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Sarah-Jane Pedler

Date: 7th July 2016

Caring for women involved in surrogacy
Appendix 3

**Surrogacy Postnatal Period Checklist**

The Surrogate Mother is the "carrying" mother and therefore, in law is the legal mother of the child at birth. This applies even where there is full surrogacy and the Surrogate Mother has no genetic link to the child. The Surrogate Mother often hands over responsibility to the Intended Parents on an informal basis, at birth. However, the Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parents. The Intended Parents have no legal rights over the baby until this time.

<table>
<thead>
<tr>
<th>Required Actions</th>
<th>Status and Details</th>
<th>Signed and dated</th>
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<tr>
<td>Surrogate Mothers capacity confirmed by a registered midwife</td>
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<tr>
<td>Parental responsibility explained to surrogate mother and intended parents by registered midwife, co-ordinator or Matron</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surrogate mothers wishes documented, signed and filed in the notes relating to wishing delegated responsibility to the intended parents.(RCHT/M/S/DR 1)</td>
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<tr>
<td>Consent (RCHT/M/S/CTL 1) from the surrogate mother for the baby to leave hospital with the intended parents</td>
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<td></td>
</tr>
<tr>
<td>Intended parents <strong>Temporary</strong> discharge details –</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone numbers</td>
<td></td>
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<tr>
<td></td>
<td>GP name and telephone number</td>
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<tr>
<td></td>
<td>Midwife name and telephone number</td>
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<tr>
<td>Intended parents <strong>Permanent</strong> discharge details –</td>
<td>Address</td>
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<tr>
<td></td>
<td>Telephone numbers</td>
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<td></td>
<td>GP name and telephone number</td>
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<td></td>
<td>Midwife name and telephone number</td>
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<tr>
<td><strong>Surrogate mothers</strong> follow up midwifery care and GP in the community</td>
<td>Name of Midwife/date of referral</td>
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Caring for women involved in surrogacy
The Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parents. The Intended Parents have no legal rights over the baby until this time.

I ……………………………………….. ………..
[insert full name of surrogate mother, date of birth] Delegate informally responsibility for decisions made regarding ………………………………………... [insert name and date of birth of the child] to the intended parents detailed below.

I ……………………………………….. ………..
[insert full name of surrogate mother] consent for ……………………………………… ……[name of child] to leave hospital with the intended parents detailed below.

Intended Parents details

Parent 1…………………………………………………………………………
Parent 2…………………………………………………………………………

[insert full names of both intended parents including date of birth]

Signed by – Surrogate Mother……………………………..Dated:………………

Signed by - Intended Parent 1 ............................. Dated: ………………….

Signed by - Intended Parent 2 .............................Dated: ………………….

Witnessed by –

Registered Midwife…………………………………………………..Dated: ………………….

Confirmed by –

Coordinator/Matron……………………………………….Dated:……………….

Copies of both pages to:

Baby’s record
Surrogate mothers record
Intended parents