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Royal Cornwall Hospitals NHS Trust

Caring for Women Involved in Surrogacy Clinical Guideline

V3.0

February 2023

1. Aim/Purpose of this Guideline

1.1. This guideline has been developed to provide the multi-agency team with clear guidance to enable sensitive, non-judgmental, and rights-respecting care for surrogates in pregnancy, birth and postnatal period while also considering the support needs and wishes of the intended parents. While the safety and wishes of the surrogate are paramount, the aim of this guideline is to ensure an approach to care in surrogacy that facilitates a safe, positive, and rewarding experience for all.

1.2. This version supersedes any previous versions of this document.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

1.4. Signpost all those considering or involved in surrogacy to the following resources:

- https://brilliantbeginnings.co.uk/
- https://surrogacyuk.org/
- https://www.surrogacy.org.uk/
- https://www.mysurrogacyjourney.com/

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Definitions

Intended parents are couples or individuals who are considering surrogacy to become a parent. To apply for a parental order at least one of the intended parents must be a genetic parent of the child born to them through surrogacy. Intended parents generally prefer to be referred to as the parent(s) of the child.

Surrogate is the preferred term for birthing people who are willing to help intended parents to create families by carrying children for them. A surrogate may or may not have a genetic relationship to the child that they carry for a couple. Surrogates generally do not prefer to be referred to as the mother or parent of the child.

2.2. There are two types of surrogacy

2.2.1. Straight surrogacy is when the surrogate uses their own egg, which is fertilised with the intended parent's sperm; this may be done by self-insemination using a syringe or done in an infertility clinic.

2.2.2. Host surrogacy is when the surrogate carries the intended parent's genetic child conceived through in-vitro fertilization at an infertility clinic.

2.3. Legal aspects of surrogacy

2.3.1. Altruistic surrogacy is legal and is a positive option for those seeking to start a family through assisted reproduction in the UK.

2.3.2. 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.

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

2.3.4. Surrogates can, however, receive reasonable expenses from the intended parents, such as for pregnancy clothing, insemination and IVF costs and travelling to and from hospital.

2.3.5. Staff should be alert to any third parties (i.e., other than the surrogate or 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 Named Midwife for Safeguarding, for further advice and guidance.

2.3.6. In the United Kingdom the birthing person is the legal parent irrespective of the conception method and genetic make-up of the baby.

2.3.7. If the surrogate is married or in a relationship, the partner will also assume legal parenthood status of the child from birth until the parental order is made.

2.3.8. A surrogacy arrangement is not a legally binding contract and therefore an arrangement between the surrogate and the intended parents is not enforceable. Either party are therefore free to change their mind at any time.

2.3.9. Legal parenthood can be transferred to the intended parents through a parental order made by the family court. Intended parents can start the process to obtain a parental order from 6 weeks until 6 months after the birth if certain criteria are met, including the child being in their care, having the consent of the surrogate, and at least one intended parent or the intended parent, in the case of a single applicant, being genetically related to the child.

2.3.10. Under English law, once the Parental Order is granted, the 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

2.4. General guidance

2.4.1. When surrogacy has taken place with the assistance of a fertility clinic, all parties involved in the surrogacy arrangement should have been offered counselling to discuss the implications and potential challenges faced by them. If the surrogacy arrangement has taken place without the aid of a fertility clinic, then implications counselling should be recommended to both surrogate and intended parents (including the surrogate's partner if applicable) at the antenatal stage. See: https://www.bica.net/

2.4.2. Health care professionals have a legal duty of care to the surrogate and the baby once born. The wishes of the surrogate are paramount, and the intended parents will only become involved with the express consent of the surrogate.

2.4.3. 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 express consent of the surrogate.

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

2.4.5. The Director of Midwifery, Consultant Midwife and Ward Manager should also be informed if an intended parent requests to stay in hospital to receive support and guidance related to parenting skills and care of the newborn.

2.5. Mental capacity of the surrogate to make decisions

2.5.1. Should staff have concerns regarding the mental capacity of the surrogate affecting her capacity to make decisions relating to their care, or the surrogacy agreement, a formal assessment of mental capacity should be requested by contacting the Psychiatric Liaison Team. To ensure a multidisciplinary team review, discuss concerns with the Consultant Midwife, manager on-call and senior Obstetrician. Inform the Maternity Safeguarding Team and liaise with the Wren team and Specialist Perinatal Mental Health team as required.

2.5.2. If the surrogate lacks capacity to make a particular decision, treatment should be given having regard for the best interests of the surrogate. As part of this process, advice should be sought from the Integrated Safeguarding Team and refer to the RCHT Safeguarding Adults Policy and Mental Capacity Act Policy.

2.6. Pre-birth

2.6.1. Antenatal screening

2.6.1.1. 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. It is therefore important that the surrogate is counselled of this risk and offered testing accordingly.

2.6.1.2. The guidance from the British Medical association also recommends that the intended parent who provides the sperm is tested prior to insemination.

2.6.1.3. Should the surrogate be identified as having a transmittable disease, staff are prohibited from sharing this information with the intended parents or other third parties without the consent of the surrogate. To do so would be a breach of patient confidentiality. The surrogate 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.

2.6.1.4. The surrogate should be offered all recommended antenatal screening tests for abnormalities. Staff should only perform tests that the surrogate has consented to. The intended parents have no authority to request testing that the surrogate does not consent to.

2.6.1.5. Should an abnormality be identified in the unborn child, staff should not share this information with the intended parents or other third party without the consent of the surrogate.

2.7. **Antenatal care**

2.7.1. It is important to recognise that the Trust's duty of care is to the surrogate. Antenatal care should be delivered in accordance with relevant clinical guidance which is based on individual risk assessment.

2.7.2. The intended parents can be involved in the process provided that the surrogate consents to this. The Trust should facilitate this so far as is practical.

2.7.3. The surrogate 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 birthing person should take precedence over the interests of the unborn child. No one else can make decisions on their behalf.

2.7.4. The intended parents will often attend antenatal appointments with the surrogate. It is good practice to ensure the surrogate is seen alone on at least one occasion to allow them to talk openly and in confidence. The surrogate should be encouraged to access support and advice independently as needed.

2.7.5. The midwife should obtain the address, GP and health visitor details of the intended parents and contact their area health visitor to share information.

2.7.6. Due to the legal complexities, health professionals should advise birthing people who are involved in surrogacy arrangements that they may wish to seek the expert advice of a lawyer. Advice can also be sought from the Trust legal team where required.

2.8. **Birth planning**

2.8.1. The surrogate and the intended parents will often complete a surrogacy agreement setting out preferences for pregnancy, birth and postnatal period, including the preferred method of birth who will be present for the birth, who will hold the baby after birth, early infant feeding and who will make decisions about the child's care. Staff should be aware that these agreements are not legally binding and should be used as a guide only. It is important to allow the surrogate opportunity to express their wishes as these may change during or following birth.

2.8.2. If a written surrogacy agreement has not yet been prepared, or if it does not adequately cover all aspects of care, then the surrogate and intended parents should be encouraged and supported to create one. Support is available from Surrogacy UK, COTS, Brilliant Beginnings and My Surrogacy Journey. Staff should be satisfied that the surrogate consents to the sharing of data/medical information and/or attendance at appointments. While it is beneficial for these discussions to take place in partnership with the intended parents, final decisions about care must be made by the surrogate.

2.8.3. Where a birth plan is completed with the involvement of the community midwife, a copy of this should be attached to the surrogate's electronic maternity records and shared with Consultant Midwife, Ward Managers and Maternity Matrons.

2.8.4. **Confidentiality-** The surrogate's confidentiality should be respected at all times. This means that no information about the surrogate or the unborn child should be shared with the intended parents or any other third party without her consent.

2.9. Care of the surrogate in the postnatal period

2.9.1. Enhanced postnatal care should be provided to the surrogate. Particular care should be paid to their psychological state and additional support offered. Additional postnatal visits may be beneficial and should be decided on an individual basis.

2.9.2. The legal guardianship of the baby remains with the surrogate, 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, even if the baby is handed over at birth.

2.9.3. The baby cannot be removed from the hospital by the intended parents without the surrogate's consent.

2.9.4. If the surrogate requires continued admission to hospital for medical reasons but the baby does not require admission, the surrogate may wish to delegate responsibility for care of the baby to the intended parents.

2.9.5. 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 and intended parents by a midwife who feels confident to discuss this. If required, a Wren team midwife can provide support. See also resources for signposting in section 1 (above).

2.9.6. A record of this discussion must be recorded and filed in the surrogate's medical notes, the baby's medical record and a copy given to the intended parents using the following forms and checklist: CHA4322: Surrogacy Postnatal Period Checklist (cornwall.nhs.uk)

2.9.7. The surrogate will require enhanced postnatal care by community midwives. This must include at least one home visit and open access for at least 28 days. When discharged from hospital this should be communicated to the community midwife, GP and Health Visitor.

2.9.8. There is mixed evidence relating to the impact of surrogacy on psychological wellbeing (Lamba et al 2018, Jadva et al 2003). What is clear is that sensitive, supportive and non-judgemental care by health care professionals positively impact mental wellbeing of surrogates.

2.10. Care of the baby in the postnatal period

2.10.1. The intended parents have no legal rights over the baby until a legal order is in place or the baby is adopted.

2.10.2. Where possible decisions about the baby's treatment should be made jointly, by the surrogate and the intended parents in conjunction with health care professionals. In most cases the surrogate will hand over responsibility to the intended parents on an informal basis, at birth. However, it must be noted that the surrogate remains legally responsible for the baby until the parental order is granted.

2.10.3. If the surrogate requests that the intended parent be permitted to stay until the baby is discharged, this should be accommodated and recorded in the notes.

2.10.4. Following the birth where the surrogate has delegated responsibility for the child, an intended parent should be accommodated wherever possible in a side room on the postnatal ward. Parenting advice and support will then be provided to the intended parent until the baby is discharged. This arrangement must be recorded in the surrogate's notes and the baby's notes, stating that this is the request of the surrogate.

2.10.5. The intended parents and the baby will require enhanced postnatal care by community midwives and the baby's discharge should be communicated to the community team, 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 intended parents' address, telephone number, local hospital and GP contact details are recorded in the antenatal records.

2.10.6. The enhanced postnatal care for baby and intended parents should focus on emotional support and the care of newborn.

2.10.7. The immediate postnatal period is a time of emotional upheaval which may be compounded in a surrogacy arrangement. Sensitivity is required in interactions with both the surrogate and intended parents.

2.10.8. In the rare event of conflict, the midwife must focus her care on the surrogate and the baby.

2.11. What happens if there is a dispute between the intended parents and the surrogate?

2.11.1. Most surrogacy cases are straightforward, positive and rewarding experience; disputes in surrogacy are very rare. The Trust should attempt to work with the surrogate and intended parents at all times. Should a dispute arise, the surrogate's wishes should be always respected, and advice sought from Consultant Midwife and the Named midwife for safeguarding.

2.11.2. If the intended parents attempt to remove the baby from the Trust premises against the surrogate's wishes, staff must inform the police- and follow the suspected child abduction policy Suspected Infant or Child Abduction Policy (cornwall.nhs.uk)

2.12. **What if the intended parents change their mind?**

2.12.1. If the intended parents change their minds about the surrogacy arrangement, the surrogate (and any married/civil partner) will be legally responsible for the child.

2.12.2. If the surrogate does not wish to continue with parental responsibility, Children's Social Care should be contacted: Complete MARU referral, inform maternity safeguarding and contact MARU (09.00-17.00) or social worker on-call (weekend/out of hours) for initial advice.

2.13. **What if the surrogate changes their mind?**

If the surrogate changes their mind and wishes to keep the baby, the Trust must respect their wishes. In this situation the courts will usually allow the birth parent to keep the baby. If there is a disagreement between the parties, the Consultant Midwife and the Named Midwife for Safeguarding must be informed. Where the Consultant Midwife is not available, the manager on-call and a member of the Wren team will be able to support.

2.14. **What if the child becomes ill and needs treatment?**

2.14.1. Where possible, decisions about the child's treatment should be made jointly, by the surrogate and the intended parents and in conjunction with health professionals.

2.14.2. In most circumstances the surrogate will hand over responsibility to the intended parents on an informal basis, at birth. However, the surrogate remains legally responsible for the baby until a parental order has been granted or the baby has been legally adopted by the intended parents.

2.14.3. If/when the surrogate informs staff that they have delegated responsibility for the baby to the intended parents, staff should consult with the intended parents in respect of decision making and seek their consent to any care and procedures accordingly.

2.14.4. Staff should request that the surrogate completes the 'Delegate Responsibility to intended parents' form (Appendix 3). The surrogate should be advised that this is an informal, non-binding agreement and that she is free to change her mind.

2.14.5. As a matter of law, the surrogate has parental responsibility at birth and therefore, has the legal right to consent/refuse treatment on behalf of their child. This is the position until the intended parents have a obtained a Parental Order or adoption proceedings are finalised

2.14.6. If the surrogate refuses treatment for the child and there are concerns that they will come to significant harm due to this, then a MARU referral must be submitted and inform the maternity safeguarding team.

2.15. **Registering a child born through surrogacy**

2.15.1. The law requires a birth to be registered within 6 weeks.

2.15.2. It is the responsibility of the surrogate to register the birth.

2.15.3. The intended parents will need to obtain a parental order to become the legal parents. The birth can then be re-registered to show the intended parents as the parents of the child.

2.16. **Source of advice and support**

- Named midwife for safeguarding
- Line Manger/Matron/Consultant Midwife/Wren Team
- Legal Department

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	All birthing people and families known to be involved in surrogacy were treated appropriately and conversations documented
Lead	Ditte Madsen
Tool	• Did the surrogate receive routine antenatal care? • Was a surrogacy agreement encouraged, supported and attached to the electronic record? • Did the surrogate receive enhanced postnatal care? • Did the intended parents receive enhanced postnatal care focused on emotional support and care of newborn? • If the surrogate informally handed over responsibility for the baby to the intended parents, was this documented in the notes using 'Delegate Responsibility to intended parents' (appendix 3)?
Frequency	Individual case reviews
Reporting arrangements	To be determined on a case-by-case basis

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Ditte Madsen
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned by the lead for this guideline. A lead member of the team will be identified to take each change forward where appropriate.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Caring for Women Involved in Surrogacy Clinical Guideline V3.0
This document replaces (exact title of previous version):	Caring for Women Involved in Surrogacy Clinical Guideline V2.0
Date Issued/Approved:	February 2023
Date Valid From:	February 2023
Date Valid To:	February 2026
Directorate / Department responsible (author/owner):	Ditte Madsen Wren team Maternity
Contact details:	Ditte.madsen@nhs.net
Brief summary of contents:	This guideline has been developed to provide the multi-agency team with clear guidance on care in surrogacy that ensures the safety and wishes of the surrogate are paramount while facilitating a safe, positive and rewarding experience for all.
Suggested Keywords:	Surrogacy host parent surrogate
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	None required
Related Documents:	Department of Health and Social Care (DHSC) (2021) Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births

Information Category	Detailed Information
	in England and Wales, Updated 23 July 2021. UK Government: OGL. Lamba, N., Jadva, V., Kadam, K., & Golombok, S. (2018) 'The psychological well-being and prenatal bonding of gestational surrogates,' Human reproduction 33(4): 646–653. Laurie, Graeme, Shawn Harmon & Edward Dove (2019) Mason & McCall Smith's Law and Medical Ethics. Eleventh edition. Oxford: Oxford University Press. Having a Child Through Surrogacy, Government Publications 2018 https://www.gov.uk/government/publications/having-a-child-through-surrogacy Vasanti Jadva, Clare Murray, Emma Lycett, Fiona MacCallum, Susan Golombok (2003) 'Surrogacy: the experiences of surrogate mothers,' Human Reproduction, 18(10): 2196–2204. https://doi.org/10.1093/humrep/deg397 Relevant Legislation Adoption and Children's Act 2002 Surrogacy Arrangements Act 1985 Human Fertilisation and Embryology Act 2008
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Maternity and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
7th July 2016	V.1	New Guideline	Treena Figg, Inpatient Matron for Maternity
September 2019	V2.0	Full review. Amendments and revision of references.	Angela Whittaker, Midwifery Matron.
February 2023	V3.0	Full review with amendments and update of references	Ditte Madsen Specialist Wren Team Midwife

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 for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Caring for Women Involved in Surrogacy Clinical Guideline V3.0
Directorate and service area:	Obs and Gynae Directorate
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Ditte Madsen
Contact details:	01872 25 2684

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This guideline has been developed to provide the multi-agency team with clear guidance to enable sensitive, non-judgmental and rights-respecting care for surrogates in pregnancy, birth and postnatal period while also considering the support needs and wishes of the intended parents.
2. Policy Objectives	While the safety and wishes of the surrogate are paramount, the aim of this guideline is to ensure an approach to care in surrogacy that facilitates a safe, positive and rewarding experience for all.
3. Policy Intended Outcomes	Well informed supportive and appropriate care for surrogates in pregnancy birth and postnatal period. With the express consent of the surrogate, to offer support and inclusion of the intended parents.
4. How will you measure each outcome?	Compliance monitoring tool
5. Who is intended to benefit from the policy?	Surrogates and intended parents

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: Yes • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Midwifery and Obstetrics guidelines Group Maternity Voices Partnership
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** **No**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g., physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Ditte Madsen

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Delegate Responsibility/Consent to Leave Hospital Form

The surrogate 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, 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]** 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……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's record

Intended parents

Awaiting CHA number