Avery's Angels
GASTROSCHISIS FOUNDATION

SUPPORT, RESEARCH, & AWARENESS

Please obtain signature from an OBGYN, Neonatologist, Pediatric surgeon or Caseworker familiar with your case.
You may email this form to info@averysangels.org or mail to PO Box 58312 Raleigh, NC 27658.
Thank you very much!

To Whom It May Concern,
Thank you for taking the time to fill this form out for Avery's Angels ® Gastroschisis Foundation and the patient concerned. To protect the interests of the foundation, we require official affirmation and documentation of a gastroschisis diagnosis from a doctor or caseworker assigned to the case. This will enable our foundation to provide support and send out a care package to the patient. This is a necessary process to protect the
Foundation from fraud and abuse and enables us to continue to exist. We appreciate your cooperation!

Sincerely,
The Avery's Angels® Gastroschisis Team

For patient/parent:

I, _____ give my consent to release the requested information to Avery's Angels®.

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____

_____

sign & date

For Doctor (Please print your full name, title and affiliated institution):

Name & Title: _____

Hospital: _____ Telephone Number: (_____) _____

E-mail: _____

Please print your name and the patient names below:

I, _____ hereby affirm that _____ is due with/has a diagnosed gastroschisis baby. The expected due date for baby is _____ and the sex of baby is _____.

_____

sign & date

Please attach/scan professional business card.