
The Fertility Center, LLC

The Fertility Center, LLC
Michele Munch, CRNP
130 Leader Heights Road
York, PA 17403

Dear _____,

Thank you for your interest in egg donation. In advance, we would like to thank you for considering under taking a process that may provide a wanting recipient with the ultimate gift. Such consideration is worthy of an initial thanks and we look forward to working with you.

The screening process takes a minimum of three to four weeks to complete. If you are approved, it can take several weeks before you are selected by a recipient couple and then several weeks to tailor your cycle. The In Vitro Fertilization (IVF) process itself takes a further three weeks to complete. Unfortunately, we are unable to guarantee your entry into the program and while you may be selected into the program, this does not guarantee that you will be selected by a recipient. If you do not qualify for our program, you will be informed of this decision.

The financial compensation, released after the IVF cycle has been completed, is \$4,000.00. Because it is considered earned income, it is taxable, reported to the IRS (as required by law) and needs to be declared on your tax return.

If you decide to apply (you must be 21 years of age) to be an egg donor, please complete the "Donor Information and Medical History" form and the "Donor Information Face Sheet" and return them to us. After we review the form, you will be notified of your eligibility to continue on to the next phase of the process. At that point we will give you further guidance to allow you to move through the process at your pace.

You will find the following enclosed documents which we hope will answer some of your questions:

- "Egg Donation Program Goals"
- "Steps in the Egg Donation Process"
- "Donor Information and Medical History"
- "Patient Instruction for IVF"
- "Donor's Consent Document."

Please read all documents with care and feel free to call me at 717-747-3009 if you have any questions or concerns regarding the enclosed materials.

Again, thank you for your interest in our program.

Sincerely,
Michele Munch, CRNP
Donor Egg Coordinator

Initials_____

The Fertility Center, LLC

130 Leader Heights Road York, PA 17403

Egg Donation Program Goals:

1. To provide care in an empathetic manner.
2. To help achieve fulfillment regarding reproductive pursuit.
3. To provide timely service.

Egg Donation Program Requirements:

The following are required as part of the approval process:

1. Completion of the "Donor Information and Medical History" form.
2. Lab appointment for blood draw on day 2 or 3 of your menstrual cycle, if over 30 years old.
 - a. If you are taking oral contraceptive pills please inform the Egg Donor Coordinator of this when scheduling this blood draw.
3. Two sessions with the Egg Donation Program Psychologist.
 - a. Joan Bitzer at Psychological Associates of PA
717-755-0921
4. A meeting with a member of the Egg Donation Program Medical Staff.
 - a. This includes a complete physical examination and a screen for infectious diseases.
 - b. This may also include blood testing to screen for genetic disease(s).

Initials_____

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130 Leader Heights Road York, PA 17403

Donor Egg Program

Medical/Genetic History
Lifestyle history
MMPI*
Physical Exam

Blood Tests**

Blood Type and Rh factor
FSH level on day 2 or 3 of cycle
Estradiol Level on day 2 or 3 of cycle
Hepatitis B serology
Hepatitis C serology
RPR serology
HIV type 1 and type 2
Cystic Fibrosis screening

* Testing performed under the direction of our clinical psychologist.

**You will also need a recent PAP smear and cervical cultures. Additional tests are required on occasion depending on your medical history.

Initials_____

The Fertility Center, LLC

130 Leader Heights Road York, PA 17403

Donor Egg Program

The Psychological Assessment of Prospective Egg Donors

In keeping with the recommendations of our professional association, The American Society for Reproductive Medicine, we require all prospective applicants for our donor Program to complete a psychological evaluation.

This involves two, fifty-minute meetings in the offices of our Psychological Associates of PA, Joan Bitzer. Her office address is:

Psychological Associates of PA
2870 Carol Road
York, PA 17402
717-755-0921

Unless otherwise directed, please contact Joan Bitzer once the coordinator has completed the first interview with you unless. Let the coordinator know the date of your first and final appointments with Joan Bitzer. Once the evaluation is complete, please contact the coordinator for the “next-step”.

Initials_____

The Fertility Center, LLC

130 Leader Heights Road York, PA 17403

Donor Egg Program

DONOR INFORMATION AND MEDICAL HISTORY

While we understand that this form is lengthy, however because donating eggs is an entirely elective procedure, we use this tool to aid in managing both your and your recipient's case. It may be easier for you to complete it in more than one sitting.

Where you do not have the information, you can indicate "Do Not Know or Not Applicable". Information provided will be used to aid the recipient in considering you for selection. Such information will not disclose any identifying information so that the recipient will not be able to identify you.

Please note that the Egg Donation Program does not discriminate on the basis of race, creed, religion or sexual orientation.

Instructions:

1. Please fill this form out completely.
2. If you have any question, then please contact me at (717) 747-3099.
3. Please return the completed packet to:

Michele Munch, CRNP
Donor Egg Coordinator
The Fertility Center, LLC
130 Leader Heights Road
York, PA 17403

I. Identifying Information

Name _____ Today's date _____

Address

Birth date _____ Age (must be 21) _____

Occupation _____

Work phone number and hours:

(____) _____

Home phone number:

(____) _____

Initials _____

Can we have permission to leave a confidential message concerning your treatment?

Work: Yes ___ No ___ Home: Yes ___ No ___

In case of emergency, please contact: _____

Relationship: _____

Telephone: (____) _____

Pharmacy name and phone number:

_____ (____) _____

Partner's name (if appropriate) _____ Birth date _____ Age _____

Are you: Single Married Long-term relationship Separated Divorced
 Remarried

Years with present partner _____

Date of marriage (if applicable) _____

Do you and your partner have any common relatives? Yes No

Initials _____

II. Personal Information

Age: _____

Eye Color: _____ Height: _____ Weight: _____

Natural Hair Color: _____

Hair Texture: Curly Wavy Straight

Hair Density: Thick Average Thin Balding

Skin Complexion: Dark Medium Fair

Body Build: Small Medium Large

Highest Degree Attained:

High School Specialized/vocational College

Advanced Degree: _____

Race: _____

Religion: _____

Hobbies, Special interests, talents and personality traits: _____

Please describe your strengths: _____

Initials _____

Please describe your weaknesses

What is it about the opportunity to donate your eggs that appeals to you?

If you had the opportunity to tell a child born to the recipient something, what would you say?

Tell us about your weekly routine?

Initials _____

How would you describe yourself to the potential recipient?

Initials_____

III. General Family History

Relative	Ethnicity	Country of Birth	Living-Y/N	Age	Height	Weight
Mother's Mother						
Mother's Father						
Father's Mother						
Father's Father						
Mother						
Father						
Sister						
Sister						
Sister						
Sister						
Brother						
Brother						
Brother						
Your Biological Children:						

Is there a family history of family infertility? Yes No
 If yes, then whom? _____
 If yes and if known, what was the cause: _____
 Were they able to conceive? Yes No

Initials _____

IV. Personal and Family Medical History

Medical issue	Yourself	Your Biological Children	Mother	Father	Sibling (Sister/Brother)	Grandparents	Aunts/Uncles
1. Heart							
a. stroke							
b. heart disease							
c. arterial disease							
d. high cholesterol							
e. heart attack							
f. heart murmur							
g. congenital heart defect							
2. Blood							
a. anemia							
b. hemophilia							
c. bleeding problem							
d. leukemia							
e. lymphoma							
f. immune deficiency							
g. blood disorder (thalassemia/sickle cell)							
3. Respiratory (lungs)							
a. hay fever							
b. asthma							
c. emphysema							
d. tuberculosis							
e. lung cancer							
f. pneumonia							
g. cystic fibrosis							
h. other lung disease							
4. Digestive							
a. ulcers							
b. gallstones							
c. hepatitis							
d. other liver disease							
e. pyloric stenosis							
f. Crohn's disease							
g. ulcerative colitis							
h. intestinal cancer							
i. other digestive cancer							
j. other digestive disease							
5. Metabolic							
a. diabetes							
b. thyroid disease							
c. gland or hormone problem							
d. Gauchers disease							
e. hyperactivity							
6. Birth Defects							
a. cleft lip or palate							
b. clubbed foot							
c. congenital heart disease							
d. other birth defect							
7. Urogenital							
a. kidney disease							
b. other urinary tract disease							
c. un-descended testicle							
d. hypospadias							
e. prostate cancer							
f. uterine cancer							
g. cervical cancer							
h. ovarian cancer							
i. uterine cancer							
j. other genital cancer							

Initials _____

IV. Personal and Family Medical History (cont)

Medical issue	Yourself	Your Biological Children	Mother	Father	Sibling (Sister/Brother)	Grandparents	Aunts/Uncles
8. Neurological							
a. mental retardation							
b. senility before age 50							
c. mental disorder requiring hospitalization							
d. Huntington's Disease							
e. multiple sclerosis							
f. seizure disorder							
g. hydrocephalus (water on brain)							
h. disorder of the brain, spine or nervous system							
i. delayed development							
j. loss of coordination							
k. Parkinson's Disease							
l. migraine headaches							
m. undiagnosed headaches							
9. Psychological							
a. major depression							
b. bipolar disease							
c. schizophrenia							
d. Tourette's syndrome							
e. personality disorder							
f. other psychotic disorder							
10. Eyes/Ears							
a. deafness before age 60							
b. cataracs							
c. glaucoma							
11. Musculo-Skeletal							
a. muscular dystrophy							
b. other chronic muscle illness							
c. deformity of the spine							
d. spina bifida							
e. scoliosis							
f. rheumatoid arthritis							
g. extremely short							
h. extremely tall							
i. congenital hip problem							
j. brittle bones							
k. gout							
l. dwarfism							
m. osteoporosis							
12. Miscellaneous							
a. lupus							
b. eczema							
c. skin cancer							
d. breast cancer							
e. drug or alcohol problem							
f. thrombosis (blood clot, DVT or pulmonary embolus)							
g. early death (less than 50)							
h. coffee colored spot on the skin							
i. quarter or large sized lumps under skin							

Initials _____

j. other (please indicate)							
----------------------------	--	--	--	--	--	--	--

Initials_____

V. Previous hospital admission (any reason) Medical/Surgical:

Where (hospital, city)	When	Reason	M.D.

Have you ever had an abnormality in any of the following:

- EKG
 Mammogram
 X-ray
 Other diagnostic test

If yes, please specify results: _____

Have you ever been the victim of sexual or physical abuse? Yes No

If yes, have you received counseling for this? Yes No

Initials _____

VI. GYN History

Date of most recent period (1st day) ____/____/____

Age of first period? _____ Usual number of days from one period to the next: _____

Usual duration of bleeding: ____ days. Are your periods regular? Yes No

Do you have cramps? None Minimal Moderate Severe

Is pain medication necessary? Yes No

If yes, which type? _____

Is intercourse painful or difficult for you or your partner? Yes No

Date of last pap smear ____/____/____ Results _____

Do you have a history of an abnormal pap smear? Yes No

If so, have your recent pap smears been normal? Yes No

Do you suffer from: Chronic pelvic pain Endometriosis

Have you or your sexual partners ever had any of the following:

- Pelvic Infection (PID) Chlamydia Herpes
- Syphilis HPV(genital warts) Gonorrhea Tuberculosis (TB)
- HIV Hepatitis Non-specific urethritis
- Other sexually transmitted disease(s): _____

VII. Obstetrical History

Have you ever been pregnant? Yes No

If yes:

Delivery Month & Year	Outcome * (see below)	How long to conceive?	Sex and Weight of infant (if delivered)	If Miscarriage - D&C done?	Complications Y / N

*Vaginal delivery: **V**, C-Section: **C/S**, Miscarriage: **M**, Abortion: **A**, Ectopic/tubal Pregnancy: **EP**

Initials _____

Do you have a heart murmur requiring antibiotics with surgical procedures? Yes No

Do you need antibiotics when you have dental work done? Yes No

Do you have any allergies to medications or **latex**? Yes No

If yes, please list: Medication _____ Reaction: _____
Medication _____ Reaction: _____
Medication _____ Reaction: _____

Currently used daily medications: _____ Reason: _____
_____ Reason: _____
_____ Reason: _____

Are you taking vitamins containing Folic Acid or a Folic Acid supplement? Yes No

Initials _____

VIII. Children's Developmental History

Child	1	2	3	4
Age				
Sex				
Weight				
Height				
Eye Color				
Hair Color				
Body Size				
Age began walking				
Age began using sentences				
Age potty trained				
Hyperactive				
Discipline problems				
Regular prescription medications				
Emotional problems				
Attention deficit disorder				
Reading difficulties				
Speech difficulties				
Requires special services at school				

Initials _____

IX. Genetic History

The following questions are designed to screen for common inheritable conditions.

1. Have you or anyone in your family ever had any of the following disorders:
- | | | |
|---|-----------------------------|------------------------------|
| Down syndrome (mongolism) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other chromosomal abnormality | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Neural tube defect, i.e., spina bifida
(meningomyelocele or open spine), anencephaly | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hemophilia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Turner syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Klinefelter syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cri Du Chat syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fragile X syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Muscular dystrophy | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cystic fibrosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sickle Cell Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tay Sachs | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other genetic illness: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes, indicate the relationship of the affected person to you:

2. Did you or your children have any learning disabilities while growing up? No Yes
If yes, whom and what is it? _____
3. Do you or do you have a child with a birth defect? No Yes
If yes, who has the defect and what is it?

4. Have you had a child born, dead or alive, with a birth defect not listed in question 2 above? No Yes
If yes, who has the defect and what is it?

5. Do you have any close relatives with mental retardation? No Yes
If yes, indicate the relationship of the affected person to you: _____ Indicate
the cause, if known: _____

Initials _____

6. Do you or a close relative have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? No Yes
If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: _____

7. At any time, have you had a stillborn child or more than two pregnancy losses? No Yes

If yes, how far along were you when you had the pregnancy losses?

1st _____
2nd _____
3rd _____

If yes, have you had a study of your own chromosomes? No Yes

8. Have you or a relative terminated a pregnancy because of a chromosomal abnormality? No Yes

If yes, please explain: _____

9. Are you of Ashkenazi Jewish ancestry? No Yes

If yes, have you been screened for Tay-Sachs disease? No Yes

If yes, indicate the results: _____

10. Are you of French-Canadian ancestry? No Yes

If yes, have you been screened for Tay-Sachs disease or Cystic Fibrosis?
 No Yes

If yes, indicate the results: _____

11. Are you African or African American? No Yes

If yes, have you been screened for sickle cell? No Yes

If yes, indicate the results: _____

12. Are you of Italian, Greek, or Mediterranean background? No Yes

If yes, have you been tested for thalassemia? No Yes

If yes, indicate the results: _____

13. Are you of Philippine, Southeast Asian, or Indian ancestry? No Yes

If yes, have you been tested for thalassemia? No Yes

If yes, indicate the results: _____

Initials _____

X. Review of Systems

Please check if any of the following have been present:

- | | | |
|---|---|--|
| <input type="checkbox"/> Enlarged glands or lymph nodes | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Poor sense of smell |
| <input type="checkbox"/> GI reflux; heartburn | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart palpitation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Breast discharge |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hot flushes | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> History of pelvic infection | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Light headiness |
| <input type="checkbox"/> Breast lump/cyst | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Excessive hair growth | <input type="checkbox"/> Weakness/fatigue |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Unusual hair growth |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Chronic diarrhea/constipation | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Chronically warm or cold | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Vaginal itching | | |
| <input type="checkbox"/> Venereal Disease | | |
| <input type="checkbox"/> Chronic muscle aches/joint pain | | |
| <input type="checkbox"/> Problems sleeping/or staying awake | | |
| <input type="checkbox"/> Bleeding tendency; bruise easily | | |

Have you suffered from any the following:

Have you **been vaccinated** for Rubella (German Measles)? Yes No

Have you had or been vaccinated for Chicken Pox(if Yes, please circle which)?
 Yes No

Have you had or been vaccinated for Hepatitis (please circle which, if yes)
 Yes No

Present weight: _____ lbs. Weight 2 years ago: _____ lbs.

Are you frequently exposed to organic solvents, chemical toxins or X rays?
 Yes No

Have you ever smoked? Yes No
If yes: Number of packs/day _____ If you stopped, when _____

Caffeine intake: Cups/day: Coffee _____, Tea _____, Cola _____

Alcohol: Yes No
If yes: Number of drinks/day _____

Do you exercise? Yes No
If yes please indicate the type, duration, and how often: _____

Initials _____

X. Review of Systems (cont)

Have you ever used any non-medical or recreational drugs including marijuana? Yes No

If yes please list substances used: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever used intravenous drugs? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever had sexual relations with an intravenous drug user? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever exchanged sexual favors for some compensation including drugs? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever used had sexual relations with a homosexual or bisexual male? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever tested positive to HIV, Syphilis, Hepatitis B or Hepatitis C? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you ever had contact to blood from someone with known HIV or hepatitis? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Initials _____

Have you ever been in prison? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent)

I consent to disclosure of this information

I do not consent to disclosure of this information

Have you ever undergone tattooing, body piercing or acupuncture in which sterile technique was not used? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent)

I consent to disclosure of this information

I do not consent to disclosure of this information

Have you ever received a human organ transplant? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent)

I consent to disclosure of this information

I do not consent to disclosure of this information

Initials _____

X. Review of Systems (cont)

Do you have hemophilia. If yes, do you use human-derived clotting factor? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you had sex in the preceding 12 months with any person described in the previous 4 items of this section or with any person known or suspected to have HIV infection, clinically active hepatitis B infection, or hepatitis C infection? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, and /or HCV – infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non-intact skin, or mucous membrane? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you had close contact within 12 months preceding donation with another person having clinically active hepatitis (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly)? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you been diagnosed with viral hepatitis after age 11? Unless evidence from the time of illness documents that the hepatitis was identified as hepatitis A (e.g., a reactive IgM anti-HAV test)? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you had a recent smallpox vaccination (vaccinia virus) in the last 60 days? If less than 60 days did the scab separate by some other means than spontaneously? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Initials _____

Have you had both a fever and a headache (simultaneously) during the 7 days prior to donation? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you, your sexual partner, or any member of his/her household ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you had a transfusion or received blood or blood products in the last 48hrs? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Has anyone in your family been diagnosed with either transmissible spongiform encephalopathy (TSE) or Creutzfeldt-Jakob disease (CJD)? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you ever taken human pituitary-derived growth hormone? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Initials _____

Have you ever received a dura mater transplant? Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you spent three months or more in the UK between 1980 and 1996?

Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Are you a current or former U.S. military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, and the Netherlands) for 6 months or more between 1980 and 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy)?

Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you lived cumulatively for 5 years or more in Europe from 1980 until the present?

Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?

Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?

Yes No

If yes please list when: _____

(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information

I do not consent to disclosure of this information

If this is a repeat donation within 6 months of your last full medical history interview have the answers to the above questions changed?

Yes No

If yes please list how: _____

Initials _____

The following questions need only be asked if there is a SARS outbreak in the world.

Contact the CDC website (<http://www.cdc.gov/ncidod/sars/index.htm>) or call CDC (888-246-2675) to obtain the up-to-date information concerning areas affected by SARS. If there is cases of SARS ask the following questions, otherwise note N/A.

Have you traveled to or resided (the areas affected) in the last 14 days?
 Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you had close contact with someone who has traveled to or resided (the areas affected) in the last 14 days? Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you been treated for SARS or suspected you had SARS in the last 28 days?
 Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Have you had close contact within the previous 14 days with persons with SARS or suspected SARS. Yes No

If yes please list when: _____
(all related information will be kept confidential and released to the potential recipient only with your consent) I consent to disclosure of this information
 I do not consent to disclosure of this information

Please be aware that our practice does not provide primary care services (for example: pap smears and other routine health screens and issues) and we request that you obtain this care from your primary care physician and/or gynecologist.

The above information is correct.

Signature

Date

Initials_____

The Medical Faculty Associates

The George Washington University

Division of Reproductive Endocrinology, Fertility & IVF **Donor Egg Program**

Anonymous Donor Egg Informed Consent

The George Washington-MFA Informed Consent for the Donor Egg Program is detailed below. This document describes the procedures in which I will be asked to participate, the significant risks and benefits, as well as alternatives, if they exist. It also requires me to meet certain responsibilities as a result of participation in the Program.

By signing this Informed Consent, I will be voluntarily agreeing to participate in a program to anonymously donate some of my eggs to another woman to help her have a child or children. My donated eggs will be fertilized in the laboratory by the sperm of the husband of the intended parents (the recipients) by means of In Vitro Fertilization (IVF). If fertilization takes place, my fertilized eggs will then be transferred into the uterus or tubes of the recipient in the hope and expectation that a pregnancy will ensure. The embryo(s) resulting from such fertilization may also or alternatively be cryopreserved (frozen) for later transfer in attempt(s) to initiate a pregnancy or pregnancies. The ownership of and all privileges and responsibilities deriving from such ownership will be completely those of the recipient couple and not my own.

I will agree to a medical and genetic evaluation by history and to a psychological evaluation of my fitness as an oocyte (egg) donor. I also agree to a pelvic examination and to a battery of laboratory screening tests which will include screening for sexually transmitted diseases, infectious diseases and general health.

Techniques and Risks:

THE PROCESS OCCURS IN STAGES:

1. **Use of GnRHa agonists (gonadotropin-releasing hormone agonist):** these drugs are utilized to prevent the woman from ovulating prematurely before the eggs are actually retrieved. It is administered by subcutaneous injection (under the skin) on a daily basis. There are two standard regimens involving GnRHa (Lupron).
 - a. Short Protocol (Flare-up) involves concurrent initiation of GnRHa immediately followed by ovulation induction agents. The GnRHa begins on day 1 or 2 of menstrual cycle.

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- b. Long Protocol (Luteal or Follicular Initiated Suppression):
Before stimulating the ovaries with fertility drugs, the ovaries are temporarily “turned off,” so there are no active follicles. In this manner, subsequent follicular (egg) recruitment and development can be enhanced. We achieve this suppression of the ovaries by using GnHRa (Lupron). This drug is administered subcutaneously in a daily dose.

Side effects of GnRHa (Lupron) may include hot flashes, headaches and possibly allergic reactions. On average, 9-12 days of Lupron are needed to achieve suppression before advancing to the stimulation phase. A vaginal ultrasound examination of the ovaries and estrogen blood level will be done to assess whether the ovaries are adequately “turned off” or suppressed before proceeding to ovulation induction.

Or, use of a GnRh Antagonist, Antagon.

Antagon also prevents a premature LH surge but has the advantage that it acts more quickly than Lupron, so, only needs to be administered daily once the follicles have grown to an appropriately. Additionally, there may be pre-treatment with oral contraceptive (birth) control pills for cycle coordination and regulation.

2. **Inducing and monitoring development (ripening) of the egg(s) in the woman’s ovaries**, to control the timing of egg maturation and to increase the chance of collecting multiple eggs, induction. These drugs are traditionally well tolerated. In a small minority of patients bloating or mood swings may occur. When used in non-IVF cycles, there are a number of embryos replaced during IVF (see below). When using Pergonal, the ovaries may become hyperstimulated leading to cyst formation, bloating, pain and increased weight gain. Despite aspiration of the follicles (cysts) during the egg retrieval process, hyperstimulation can still occur. This will be closely monitored by the IVF team as I keep us apprised of symptoms. Severe cases involving bleeding and shock are rare, but mild to moderate cases are not at all uncommon. Fertility drugs have also been implicated as possibly leading to an increased risk of ovarian cancer in fertility patients. Since drug therapies used to treat infertility have been introduced, no link between these drugs and the occurrence of any type of cancer (including ovarian cancer) has been established. An allergic reaction to any of the drugs used during the treatment cycle is also possible although rare.

Vaginal ultrasound examinations are used along with hormone blood tests to assist in predicting the time of expected ovulation and, therefore, egg recovery. While ultrasound is today considered painless and safe, it cannot be excluded that repeated ultrasound examinations might possibly cause harm to the egg(s) or to the offspring who may subsequently result from those eggs.

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Mild discomfort and possibly a bruise, bleeding, infection or scar tissue at the needle sites may be associated with blood drawing and injections of medication. The need for repeated ultrasound examinations and hormone tests on a daily basis during the days of monitoring requires my presence in the Washington, DC area for several days prior to the egg retrieval.

3. **Collecting the ripe eggs from the woman's ovaries:** The eggs are generally collected from the ovaries for In Vitro Fertilization by the transvaginal ultrasound route. An alternative means of collection is by laparoscopy (not performed for this purpose in our center).

The transvaginal method of egg recovery is less involved than laparoscopy.

Transvaginal ultrasound egg retrieval may seem a novel approach until one realizes that in most women in the ovaries, made "heavy" with follicles (small fluid filled sacs in which the eggs reside), are displaced low in the pelvic cavity at the top of the vagina and behind the cervix. In fact, the follicles are usually less than 1 inch from the top of the vaginal canal. A vaginal ultrasound probe with a needle guide attached is placed into the vagina and the ovaries are visualized on the screen. The woman may be able to observe this procedure and the doctor may be able to converse with her as to what is happening. After cleansing the vagina with sterile saline, an aspiration needle is passed along the needle guide and through the left or right upper vaginal wall alongside the cervix. Under visualization on the ultrasound screen, the needle is directed in turn into each follicle in the ovary. The fluid contents of the follicle are aspirated into small tubes are given to our IVF laboratory for scrutiny to find the egg. Not all fluid aspirated will contain an egg. Each follicle is separately aspirated and irrigated in order to optimize the number of eggs collected.

The position of the ovary(s) may be such that passing the needle through the vagina to get to the follicles by ultrasound guidance may not be possible or successful because the ovary (ies) are high in the body cavity or move too freely. In these circumstances, at the discretion of the IVF team, the needle may be directed through the bladder (using ultrasound guidance) in order to retrieve the egg(s). In rare circumstances, the position of the ovary may not allow egg collection for technical reasons (i.e. adherent above the uterus).

I understand that the most likely risks of ultrasound guided needle aspiration of the eggs include, but are not limited to:

- a.) Allergic reaction to the cleaning solution
- b.) Allergic or adverse reaction to the intravenous or local anesthetic agents or pain medications, or other anesthesia that may be used.
- c.) Discomfort and possible injury to the small vein in the arm from the drawing of the blood or insertion of the intravenous line.

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- d.) Possible injury to the bladder, including bleeding or infection or creation of canals (fistula), which continue to drain urine from the bladder to the skin surface or inside the body cavity, especially if aspiration of follicles require placing the aspiration needle through the bladder wall.
- e.) Possible injury to the bowel, including bleeding or infection within the body cavity.
- f.) Possible injury to the uterus including injury to the blood vessels, causing bleeding.
- g.) Possible injury to the ovary, other internal organs, or the abdominal wall, causing bleeding, infection and/or scarring around the ovary. This could lead to future difficulty conceiving, pain from scarring, loss of ovarian function and/or need to remove one or both ovaries.
- h.) Possible injury to the vagina, rectum, and/or uterus when the needle is passed through the vagina.

Donor Medications/Records

I consent to and agree that my donation of eggs will be on an anonymous basis and that no entry will be made on my personal medication record as to the disposition of any eggs that may be obtained from me. Furthermore, I understand that the identity of the recipient to whom I donate my eggs will not be disclosed anywhere on my personal medical record. However, I understand and give consent to the fact that for legal reasons and in order to manage health care and other records may be maintained that contain information pertaining to my egg donation cycle, including details of my genetic and medical history. These anonymous records would be available to any child resulting from donation of my egg(s).

I understand that currently, the law in the District of Columbia does not directly address that issue of the custody of children born as a result of donated eggs. I understand that while any child conceived as a result of an IVF procedure using my eggs would be my genetic offspring, I now totally relinquish any and all rights and agree never in the future to assert any parental rights which I may have regarding such eggs, concepti, embryo(s), fetuses, child or children. Instead, the recipient and her husband will have exclusive control and rights with respect to each and every egg, conceptus, embryo, fetus or child. I also understand that the recipient of the eggs I donate her and her husband will be required to agree that children born as a result of the IVF procedure using eggs that have been donated shall be their children, and they shall agree to discharge the unusual parental responsibilities.

ALTERNATIVES

There are no viable alternatives for my egg donation through the IVF process other than a refusal to participate in the voluntary process. Furthermore, if fertility drugs are not used, the egg yield during a "natural" rather than a stimulated cycle would be just one and this would compromise the recipient's chances of achieving a pregnancy.

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ACKNOWLEDGEMENTS OF INFORMED CONSENT / AUTHORIZATION

I, _____ (Egg Donor) am voluntarily participating in The George Washington Medical Center's Donor Egg/IVF Program, hereinafter called "Program," to have eggs donated through the IVF technique. I acknowledge that I have read and fully understand this Informed Consent document as well as the IVF Instruction documents. I further acknowledge that I have been given the opportunity to ask questions of the physicians and that all of my questions concerning the Program have been answered to my full satisfaction, in particular the potential risks and possible adverse consequences that may be involved.

By participating in the Program, I accept the responsibilities, conditions, and risks involved which are outlined in this document, as well as in the other Program documents I have been given and which have been explained to me by the IVF/ET team.

I agree to screening by history, to physical examination, to blood tests and to psychological evaluation of my fitness as a donor.

If there are alternative means, I have been advised of them. I still wish to make use of the Donor Egg IVF team. I make this choice with the knowledge that the practice of the anesthesia, medicine and surgery is not an exact science and admit that no one has given me the promises and guarantees about treatment or care to be received, or their results.

I hereby acknowledge that all information provided in my medical history, or in response to other inquiries, concerning my current health status is correct to the best of my knowledge. If it is found that I, the donor, have withheld information concerning material information that would affect this Program, then reimbursement of expenses for the cost of care received, or, to be received (shared donors only), or any financial compensation due, may be withheld, and I, the donor, may incur legal liability as well.

I understand that I must agree to abstain from sexual intercourse from the day I begin to have my cycle monitored until I return for my IVF follow-up examination or until I am relieved of this obligation by the Program Coordinator. In addition, I agree to abstain from sexual intercourse or to use a barrier form of birth control during the fertile days of the cycle in which I begin injections of Lupron. I agree to carry out daily LH testing during this cycle for the purpose of identifying my fertile days.

I understand that while a child or children born following an IVF cycle in which I donate my eggs is my genetic offspring. I am now relinquishing any and all rights which I may otherwise have had to control the disposition of the egg(s) which I donated and any concepti, embryo(s), fetuses or children resulting from fertilization of my eggs with the sperm of the recipient's husband. I understand that the recipient and her husband shall exercise exclusive control over said egg(s), concepti, embryo(s) or fetuses.

I acknowledge and agree that my acceptance into the Program and my continuing participation depends solely upon the discretion of the IVF/ET team. I understand that the stimulated egg donation cycle may be canceled if my physician feels that there is an undue

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risk to my health or welfare of continuing in the Program, or, if my response to the cycle medication is less than optimal. I further understand that I can withdraw from the Program at any time by written notice to the IVF/ET physicians without affecting the availability of other present or future medical care at The George Washington University Medical Center.

Although I may withdraw from the Program at any time before egg fertilization, after that time, I may not assert certain rights. I may not change my mind about relinquishing parental or other rights, regardless of the outcome of my IVF donation cycle.

I understand in particular that I may participate in the Donor Egg Program as described above with the understanding that the medications and procedures to which I voluntarily consent are not administered as treatment for any medical condition or abnormality that I have, but only as a voluntary procedure with the sole purpose of donating eggs for someone else's use (unless I am sharing eggs as part of my own clinically applicable IVF cycle).

FOR ANONYMOUS PAID DONORS:

The recipient of the donated eggs will bear the cost of the IVF procedure involving the egg donor. **Any complications from this procedure will be borne by the donor.**

FOR ANONYMOUS "SHARED" EGG DONORS

If I have agreed to share a portion of my eggs with a recipient, I will be responsible for some of the costs of the cycle, namely: pre-cycle screening cycle medications, culture and fertilization of the portion of the eggs I retain with the sperm of my partner (including preparation of the semen specimen) and any additional cost involved for male factor infertility or for the procedure called ASSISTED HATCHING. The recipient will be responsible for the cost of the monitoring my response to the fertility drugs (pelvic ultrasounds and blood tests), hospital and anesthesia costs and the cost of the egg retrieval procedure.

I have read and fully understand the contents of this form, as well as the general INF Instructions document. I have been given the opportunity to ask questions of the physicians, and all of my questions concerning the contents of this consent document has been fully answered to my/our (shared donors only) satisfaction.

Signature of Egg Donor Date

Signature of Donor's Husband (if applicable) Date

Signature of Witness Date

Signature of Physician Date

Initials_____