

Female Patient Name: _____ Social Security # _____
Male Patient Name: _____ Social Security # _____

THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY*



**DONOR EGG PROGRAM AGREEMENT
DONOR**

Description, Explanation and Informed Consent

I realize that it will take a total commitment on my part to participate in the program. I understand and agree to the following:

1. To undergo any blood tests for hormone levels, infectious disease, and drug screening that are needed.
2. To undergo psychological screening as required.
3. To take all medications as instructed:
 - a. Daily injections of Lupron for 2-6 weeks.
 - b. Once or twice daily injections of gonadotropins to stimulate my ovaries to produce more than one egg.
 - c. One injection of human Chorionic gonadotropins (hCg) to help mature eggs and prepare them for egg retrieval.
 - d. The possible use of antibiotics taken by mouth to prevent infection.
 - e. Any other medications as instructed.
4. To keep all appointments for vaginal ultrasounds and laboratory tests in order to be closely monitored.
5. To abstain from intercourse or to use a non-hormonal form of contraception such as tubal ligation, condoms, or a diaphragm, if I do have intercourse during the cycle.
6. To notify the CHR staff if I engage in intercourse with a new partner.
7. To refrain from the use of all recreational drugs. To report any prescription or non-prescription drug use to CHR's egg donor coordinator.
8. To undergo oocyte aspiration which is performed by a needle being placed into my ovaries using transvaginal ultrasound guided techniques with intravenous sedation.
9. To donate all my retrieved oocytes (eggs) to a recipient who will be matched with me at the beginning of the cycle. On behalf of myself, my agents, my heirs, administrators, personal representatives, executor, or spouse, I RELINQUISH ANY CLAIM TO ALL OOCYTES (EGGS) AND/OR OFFSPRING THAT MAY RESULT FROM THE USE OF MY EGGS FOR INVITRO FERTILIZATION at the time of egg retrieval. I understand that I may be matched to more than one recipient in a given cycle.
10. That my compensation for my expenses, inconveniences, risks, and discomfort as a result of participating in and completing the egg retrieval will be \$5,000.00 and \$8,000.00 in the state of New York. I also understand that once I have begun injectable medications I will be reimbursed \$1,000.00 in the event the cycle is cancelled, through no fault of my own before egg retrieval. I realize that if I fail to comply with any treatment or requirements jeopardizing the cycle and causing it to be cancelled, I will NOT receive any compensation due to the undue psychological, physical, and financial stress I have caused the recipient couple.

*Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)

NOTE: If you or your partner are unable to have this consent witnessed by a staff member at CHR or FULLY UNDERSTAND THE CONSENT, please notify the CHR medical staff. We will provide you with further information and a witness. If you wish to sign the consent outside of CHR, please have the consent notarized.

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State of _____, County of _____ ss., I, the undersigned, a Notary Public in and for the said County in the

State aforesaid; DO HEREBY CERTIFY that _____
(Female Patient / Spouse)

personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this _____ day of _____, 20_____,

Commission expires on: _____, 20_____.

(Notary Public)

(Notary Seal)
