

Female Patient Name: _____ Social Security#: _____

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



EGG DONOR CONSENT

Description, Explanation and Informed Consent

I, _____, offer my services as a donor of eggs, which will be used in connection with Assisted Reproductive Technologies (A.R.T.) procedures carried on in connection with the Oocyte Donor Program of The Center for Human Reproduction.

I understand that I will be treated with fertility drugs, monitored using ultrasound, tested for serum (blood) hormone concentrations and subjected to such other procedures as the members of the A.R.T. Team determine are appropriate and are subsequently consented to by me. I have also been advised and understand that eggs will be obtained from me surgically by ultrasound guided aspiration of follicles in my ovaries.

I have been informed and understand that the eggs obtained from me will then be donated to a recipient to be used by the A.R.T. Team for the purpose of attempting to establish a pregnancy. I understand that the A.R.T. Team will attempt to fertilize these eggs with sperm from the recipient's male partner or with donated sperm. I have been informed and understand that if fertilization occurs and embryonic development begins, the embryos produced will be transferred to the uterus of the female recipient.

I understand that by signing this Consent to act as a Donor, I relinquish all claims to the eggs and any child that results from the use of eggs donated by me. If there are embryos generated in excess of what is safe to transfer to a recipient's uterus at a single time then the disposition of those embryos will be determined by the recipient's uterus at a single time, then the disposition of those embryos will be determined by the recipients. They may be frozen for the recipient's future use, disposed of pursuant to CHR's policies or utilized for research according to CHR's Policies. I understand that the identity of the recipients shall not be disclosed to me unless I have donated eggs for use by the following known designated recipient couple as named below: _____

Anonymous Donors Only: I have been informed and understand that my identity will not be disclosed to the couple. Likewise, I will not be given any information about the identity of the recipients. I understand that in certain cases, for medical reasons, it may be necessary for a recipient couple to seek certain medical information about my family or me after completion of the cycle. I authorize the A.R.T. Team to contact me in the future to find this information. I understand that my anonymity will be maintained.

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

I hereby consent to a physical examination, including taking blood and other body fluids, as well as a test for exposure to HIV (AIDS) virus for the purpose of giving the A.R.T. Team sufficient information to determine whether I am an acceptable egg donor. I have been informed of the potential risks and consequences of Oocyte donation, including, but not limited to, to these listed below, and have been given ample opportunity to have my questions answered.

Risks of Oocyte donation include:

1. Bruising from injections and blood draws.
2. Overstimulation of the ovaries resulting in temporary feelings of bloating and abdominal discomfort. Rarely, severe illness may result from overstimulation in an egg donor requiring additional medical care.
3. Pregnancy or multiple pregnancy may result from my having vaginal intercourse during the cycle if adequate contraception is not used.
4. During the retrieval of the eggs, sedating medications will be given to me intravenously. These medications can be occasionally associated with allergic reactions. Over sedation may result causing respiratory difficulty necessitating the use of other medication to reverse the effects of the sedation or CPR techniques as determined necessary by the physician.
5. Egg retrieval involves placing a needle from the inside of the vagina into the ovaries. I understand that it is possible to cause injury to blood vessels or other structures and this may rarely result in the requirement for additional medical care.

I hereby consent to the donation of my eggs. I understand that if I am married, my spouse must also sign this consent form.

Date	Signature of Patient	Patient Name—Print
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I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risk attendant to the donation of eggs and hereby signify my agreement to my spouse’s participation in the procedure.

Date	Spouse’s Signature	Social Security Number
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As one of the members of The Center for Human Reproduction, by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date	Signature of Witness (Female Patient)	Witness Name—Print
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Date	Signature of Witness (Spouse)	Witness Name—Print
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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.

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)