FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G.
95 Highland Avenue, #100 Telephone (610) 868-8600
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CONSENT TO PARTICIPATE IN ANONYMOUS OOCYTE (EGG) DONATION

I, ____, am over the age of eighteen (18) years, voluntarily offer my service as a donor of oocyte (eggs).

I understand that, if chosen as a donor, the eggs may be utilized in a number of ways including but not limited to the following:

(1) the eggs may be received by one infertile couple or individual or they may be shared by more than one infertile couple or individual;
(2) the individual (s) or infertile couple(s) receiving the eggs may be of any age, gender, ethnicity, sexual orientation, marital status, nationality, religion and socioeconomic background;
(3) all or some of the eggs may be fertilized immediately with sperm;
(4) all or some of the eggs may be frozen and fertilized at a latter time;
(5) the sperm used to fertilize the eggs may be produced by or retrieved from the male partner of an infertile couple, a male individual or from a sperm donor chosen by an infertile couple or individual;
(6) all or some of the embryos resulting from the in-vitro fertilization treatment may be transferred immediately in the fresh cycle;
(7) all or some of the embryos resulting from the in-vitro fertilization treatment may be frozen and transferred at a later time;
(8) the embryos will be transferred to the uterus of a (or more than one) female who is (are) the intended parent(s) or they may be transferred to a (or more than one) gestational surrogate(s); and
(9) the disposition of any excess eggs that are not fertilized and any excess embryos that are not transferred will be determined solely by the couple(s) or individual(s) who is/are the recipient(s) of the eggs. These excess eggs or embryos may be frozen for later use by the same couple(s) or individuals; destroyed and discarded; donated to other couple(s) or individual(s) for reproductive purpose; or donated for research purpose.

The infertile couple(s) or individual(s) receiving the unfertilized eggs from me will be the parent(s) of any child(ren) born as a result of the use of these donated eggs. I accept and agree that I will have neither the rights nor the duties of a parent to any offspring born as a result of my egg donation. Also, I waive any rights to any decision making regarding the use of the donated eggs. This includes but not limited to decision making with respect to:

(a) how the eggs are used: including the number of couple(s) or individual(s) sharing the entire lot of eggs from a single retrieval; the characteristics of the couple(s) or individual(s) receiving the eggs; the number of eggs to be inseminated; and whether any unused eggs will be discarded, frozen, donated to other couple(s) for reproductive purpose or donated for research purpose
(b) whom the fertilized eggs (embryos) are transferred to: whether it is the female intended parent or a gestational surrogate;
(c) when the fertilized eggs (embryos) are transferred: fresh transfer or freeze and transfer at a latter date;
(d) what will be done with any fertilized eggs (embryos) which are not transferred: whether they will be frozen, discarded , donated to other couple(s) for reproductive purpose, or donated for research purpose; and
(e) pregnancy termination in the event a pregnancy results from the fertilized eggs.

Furthermore, I waive any right to make legal claims against the recipient couple(s) or individual(s), doctor(s) involved in this procedure, and the Family Fertility Center with regard to parental rights including issues of disclosure of information, visiting rights, shared custody, inheritance and maternity.

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To the best of my knowledge:

a) I am in good health; I have no communicable disease; and I do not now, nor have I ever suffered from any physical or mental impairment or disability or ailment, except as follows:________________________
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____

b) I am not now, nor have I ever been afflicted with human immunodeficiency viruses (HIV), syphilis, gonorrhea, chlamydia, genital herpes, condyloma or any other venereal disease, except as follows:
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c) I am not now, nor have I ever engaged in behavior recognized to be risk factors for human immunodeficiency virus (HIV) infection. These include but not limited to blood transfusion prior to 1985, prostitution, intravenous drug use, sexual relationship with a partner or partner(s) known to be HIV infected or engaged in behavior generally recognized to be risk factors for HIV infection.

d) I am not now, nor have I ever had alcoholism, drug addiction, or intravenous drug abuse, except as follows:____
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____

e) None of my grandparents, parents, brothers, sisters, or children, if any, nor their lineal descendants, have ever been afflicted with emotional illness or any inherited mental or physical disabilities or disease, except as follows:____
____
____

For the purpose of determining whether I am acceptable as a donor of eggs, I consent to a physical examination, including the taking of blood and other body fluids, by the physician(s) and staff at the Family Fertility Center or any other clinical laboratory facilities whom you designate. I understand that **my blood will be tested for the presence of HIV antibodies and illegal drug use;** and that chromosomal and genetic tests will be performed. I understand that detailed health and genetic information about me and my family will be obtained. As part of a screening process, I understand that I may be required to undergo a psychological evaluation by a licensed psychological counselor or a psychiatrist chosen by the Family Fertility Center. I understand that the results of these assessments and tests will be kept on file and will be provided, on request, on an anonymous basis to the recipient of my eggs and/or any resulting offspring.

I understand that at any time during the process relating to the donation of eggs, that with the discretion of the medical team, I may be disqualified as a donor of eggs. I understand that up to the time that the eggs are removed from my ovaries, I may, at any time, withdraw my consent to donation of eggs. However, if I decide to withdraw from the donation before egg retrieval, I will not receive any compensation. Once the eggs are removed from my ovaries, I understand that **I will have no control over the use or disposition of the eggs.**

I understand that the procedure for donation of my eggs will include the following:

a) Ovarian stimulation and ovulation triggering

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I will administer to myself orally clomiphene citrate, subcutaneously Leuprolide Acetate (Lupron®) or gonadotropin releasing hormone (GnRH) antagonist (Ganirelix® or Cetrotide®), and intramuscularly/subcutaneously human menopausal gonadotropins (Menopur®), subcutaneous recombinant human gonadotropin (Brevelle®, Follistim® or Gonal-F®), and human chorionic gonadotropin (hCG) (Pregnyl®, Novarel® or Ovidrel®) which are fertility drugs to stimulate my ovaries to produce multiple eggs. Side effects of these drugs have been explained to me verbally as well as in writing in the Oocyte (Egg) Donor Risk Sheet.

b) Monitoring

I will undergo serial ultrasound examination and blood tests to determine the proper dosing of fertility drugs and timing of the egg retrieval.

c) Egg retrieval

I will undergo transvaginal ultrasound guided needle aspiration to recover the egg or eggs approximately thirty-six (36) hours after the hCG injection. A needle will be inserted into the ovary to recover the egg or eggs. It will be within the discretion of the physician to determine the number of eggs that will be removed. The procedure and risks have been explained to me verbally as well as in writing in the Oocyte (Egg) Donor Risk Sheet. The procedure is usually performed after sedatives and narcotics are given to me. I understand that I cannot drive myself home after this procedure. It is my responsibility to arrange a ride home.

The medical cost for the treatment of any complication as a result of the oocyte donation process and treatment will be covered, to the extent that is covered, by an insurance policy purchased by the recipient(s) on my behalf. However, financial compensation for any injury and any other consequential damages directly or indirectly arising from the donation of my eggs is not available. I agree that compensation will not be demanded of the physician or staff at the Family Fertility Center. Furthermore, I agree to refrain from bringing legal action of any kind, and refrain from aiding or abetting anyone else in bringing legal action for or on account of any matter or thing which might arise out of my service as a donor of eggs.

My signature below indicates that all information regarding my present and past health history is truthful. I have read and signed the Oocyte (Egg) Donor Risk Sheet. I fully understand the risks associated with oocyte donation. Furthermore, I have fully reviewed and understand the contents of this consent. I hereby consent to participate in anonymous oocyte (egg) donation and accept the risks associated with it. This consent is freely and voluntarily given by me. I have not relied on any inducements, promises or representations made by the Family Fertility Center or any of its physicians or staff. I have an opportunity to ask questions and my questions have been answered to my satisfaction.

____

Print Name of Donor Signature of Donor Date

The foregoing was read, discussed, and signed in my presence, and in my opinion the person signing did so freely, and with full knowledge and understanding.

____

Print Name of Witness Signature of Witness Date

Initials_________