OOCYTE DONOR
OUTPATIENT CONSENT FORM
Revised 12/20/12

I, ______________________, the undersigned, agree and consent to undergo ovulation induction for the purpose of obtaining oocytes (eggs) for donation.

Several individuals will be involved in my care. These include my physicians, consulting physicians, laboratory personnel, nurses, social workers, and psychologists.

PROCEDURES:

I consent to the following surgical, medical, and/or diagnostic procedures:

1. Determination by medical history, physical examination, and standard infertility tests that I am a candidate for this procedure, which will include screening for some infectious diseases, including, but not limited to HIV (AIDS), Hepatitis, Gonorrhea, Chlamydia, and Syphilis (VDRL), as well as genetic screens such as cystic fibrosis, Tay Sachs and other indicated genetic tests.

2. The use of fertility drugs (usually Lupron, FSH, and human chorionic gonadotropins {HCG}) to stimulate growth and maturation of follicles (eggs) in the ovary;

3. Laboratory tests:
   a. Blood tests - Frequent blood samples will be taken from the woman to monitor hormone secretions from the ovary and pituitary gland;
   b. Ultrasound examinations will be performed to determine the growth of the follicles. Ultrasonography is a diagnostic procedure using sound waves to provide a picture of the ovaries and the follicles;

4. Vaginal introduction of a needle into the ovary to obtain one or more eggs may be used for egg retrieval. This is performed with ultrasound guidance and under conscious sedation or local anesthesia. A Foley catheter (tube in the bladder) may be required to drain the bladder.

POTENTIAL FOR FAILURE:

I understand that the reasons the procedure may be canceled include, but are not limited to, the following:

1. The time of egg maturation may be unpredictable and misjudged. Sufficient follicular
development and maturation may not occur, thus precluding any attempt to obtain an egg(s);

2. Recovery of an egg by needle aspiration may be unsuccessful;

3. Medical emergencies with other patients may make an operating room and anesthesia unavailable at the appropriate time for obtaining an egg(s);

RISKS AND HAZARDS:

I understand that there are risks and hazards related to the performance of the planned diagnostic, surgical, and laboratory procedures, including, but not limited to the following:

1. Ovulation inducing drugs may result in over stimulation of the ovaries. This may cause pain, occasionally necessitate hospitalization, observation, and treatment and rarely result in permanent disability or death. These drugs could possibly be associated with an increased risk of ovarian cancer although current data has not shown any increased risk.

2. Blood tests may cause mild discomfort and a risk of developing a bruise and/or infection at the needle site;

3. From the ultrasonic needle aspiration there is a possibility of bleeding, infection or injury to the bladder or abdominal organs that may require immediate or later major surgery.

4. The minimal discomfort of ultrasound examinations, similar to that of a pelvic examination;

5. Anesthesia involves the use of anesthetic for the prevention of pain. Certain complications may result from the use of any anesthetic including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks range from minor discomforts, to injury to vocal cords, teeth, or eyes.

I hereby voluntarily agree to donate my egg(s) retrieved through the previously described procedures to an infertile couple(s) and agree that I will not retain, and to forever waive any right which I may have to claim, any parental rights, custody or responsibilities to said egg(s) or to any resulting embryo(s), child or children produced as a result of this donation.

I understand that if fertilization and early development of my egg(s) and the recipient husband's or donor's sperm occur normally, the resulting viable embryo(s) will be transferred to the recipient's
uterus. The recipient couple will determine the disposition of any unfertilized eggs, inseminated but non-fertilized eggs, and any remaining embryos, viable or nonviable.

In the event of unforeseen tragedy or if the recipient is rendered medically incapacitated, the embryo(s) will be allowed to progress to a state of nonviability.

I understand that the physician and his associates will, unless otherwise compelled by law, make all reasonable efforts to keep information obtained about my husband and me during the course of treatment confidential. We agree that specific medical details may be revealed in professional publication as long as our confidentiality is maintained.

I agree to submit to my insurance company any charges for complications or hospitalizations resulting from the procedures, including hyperstimulation. I understand that the recipient couple will be responsible for the expenses related to the screening procedures, ovulation induction, oocyte retrieval, and expenses for complications over and above those expenses covered by my insurance company.
I acknowledge that the ovulation induction and egg retrieval procedures, risks, and alternatives have been fully explained to me, that I have read this form or have had it read to me, and that I understand its contents. I also acknowledge that I have been afforded the opportunity to ask questions and all my questions have been answered to our satisfaction. By my signature below, I hereby agree to the provisions and consent to the procedures enumerated herein.

DONOR _______________________________ DATE __________

WITNESS _______________________________ DATE __________

I, _______________________, legally married to _______________________, hereby acknowledge and agree that my wife is voluntarily donating her egg(s) which have been retrieved through the previously described procedures to an infertile couple and agree that I will not retain, and do forever waive any right which I may have to claim, any parental rights, custody or responsibilities to said egg(s) or to any resulting embryo(s), child or children produced as a result of this donation.

DONOR'S HUSBAND _________________________ DATE __________

WITNESS _______________________________ DATE __________

I HAVE CONSULTED WITH AND EXPLAINED THE CONTENTS OF THIS CONSENT FORM TO THE COUPLE.

PHYSICIAN _______________________________ DATE __________