

# OOCYTE DONOR CONSENT

I, \_\_\_\_\_, being at least 18 years of age, hereby agree to donate oocytes (eggs) from my ovaries for the purpose of establishing a pregnancy by Overlake Reproductive Health in another woman who cannot have children. This may be related to the fact that she has dysfunctional ovaries, carries genetic defects, has naturally lost ovarian function (menopause), or has no ovaries. I understand that my eggs will be fertilized by the sperm of the male partner of the intended recipient or a sperm donor of their choosing. The embryos produced from this procedure will be transferred into the uterus of the recipient in order to establish a pregnancy. The recipient is a person with whom I am / am not acquainted or related to and I certify that I am agreeing to donate eggs of my own free will and without any coercion whatsoever.

I acknowledge that there is some medical risk associated with my participation in the Donor Egg Program. Since the procedures are more effective when more than one egg is retrieved, I understand that fertility drugs will be administered to me in order to stimulate the development of more than one egg in my ovaries. These drugs include a medication such as Antagon that will prevent me from ovulating early, as well as injections of medications called gonadotropins (Follistim, Repronex) to stimulate my ovaries. The approximate length of time that I will receive the gonadotropins is between 9 and 12 days. I will receive an injection of human chorionic gonadotropin (HCG) approximately 35½ hours prior to egg retrieval to allow the eggs to mature. The gonadotropins and HCG are natural hormones produced by the body. Possible side effects of the medications include nausea, ovarian enlargement, cyst formation, pelvic discomfort, and abdominal swelling (mild hyperstimulation). I understand that in less than 1 percent of the patients, ovarian twisting (torsion), cyst rupture, or severe hyperstimulation may occur. Severe ovarian hyperstimulation may require hospitalization and may be complicated by blood clots, kidney damage and fluid collections around the lungs. I further understand that inconclusive data exist that associate ovarian stimulation drugs like gonadotropins to the risk of developing ovarian cancer. Whereas research is underway to help clarify this issue, current data suggest that the increased risk (if any) is small. I also acknowledge that there is the possibility that my ovaries will not respond optimally to stimulation and that aspiration of my eggs will not be attempted.

The monitoring of ovarian response to the drugs will consist of daily ultrasound monitoring and blood tests for estrogen for about a six-day period. These appointments will occur in the mornings. The ultrasound monitoring will be performed using a vaginal probe that may cause discomfort similar to a gynecological exam. The risks of venipuncture are redness or bruising at the puncture site. There is no known risk to the pelvic ultrasound, which uses sound waves to evaluate the size and number of ovarian follicles.

I will then undergo a procedure to retrieve the eggs from my ovaries. This will utilize ultrasonography to locate the mature ovarian follicles. On the day of egg retrieval, an ultrasound probe will be introduced into my vagina while I am sedated with intravenous medications. I understand that a needle will be passed through my vaginal wall and into my ovaries for the purpose of obtaining eggs. The entire procedure usually takes 45 minutes and is associated with some pain and discomfort afterwards. There is a slight risk of hemorrhage from my ovaries and/or from the blood vessels in my pelvis. Such a

hemorrhage would require surgical intervention using an abdominal incision and perhaps a blood transfusion. Blood transfusion involves a risk of allergic reaction and in rare circumstances infectious diseases such as hepatitis and HIV or AIDS. The blood bank takes precautions in screening donors and in matching blood for transfusion to minimize those risks. There is also a low risk of infection from the egg retrieval procedure. I will be given antibiotics to help minimize this risk. If either of these complications occurs, I realize that I could lose one or both of my ovaries, which would result in a partial or complete loss of my future fertility. I will be given separate consent forms for ovarian stimulation and follicle aspiration procedure.

I understand that I am to abstain from intercourse during the month that I will have these procedures (from the first day of my menstrual period until my following menstrual period). If I do not abstain from intercourse during the month I participate in this program, there will be a risk of multiple pregnancy. I understand that all of the procedures, medications, ultrasound and blood tests required for donation will be performed at no expense to me.

In donating my eggs, I agree that I will have no say about the future disposition after they are retrieved from my ovaries. In particular, the woman to whom I am donating them may choose to freeze them, fertilized or unfertilized; to have them placed in her own uterus or that of a surrogate carrier; to discard them or have them destroyed; to give them up for medical research; or give them up for 'adoption' to another woman.

I agree that I shall have no legal rights or obligations for any child created through the egg donation process and agree that I shall not attempt to assert such rights.

I understand that I will be attending an interview to discuss the egg donation process and policies. I will be required to have a physical screening examination and to fill out any and all additional necessary forms as needed.

I understand that I will be screened for sexually transmitted diseases as part of the screening process. I consent to having blood drawn for a test of the AIDS antibody, hepatitis, and syphilis.

I understand that there may be a risk of passing on a sexually transmitted or other disease through the use of eggs I donate. I represent that to the best of my knowledge I do not presently have any of the following diseases; AIDS, chlamydia, gonorrhea, hepatitis, or syphilis. I further submit that I have not had sexual contact with a member of a high-risk group for AIDS, i.e. homosexuals, intravenous drug users, or hemophiliacs.

I understand that I am being asked **NOT** to participate in any of the high-risk activities described in the Risk Factor Assessment, including but not limited to tattooing, body piercing, multiple partners, unprotected sex, recreational drug use, etc., during the entire length of time that I am a potential egg donor for Overlake Reproductive Health. I agree to practice safe sex during this time period to prevent communicable disease exposure. I understand that if I do participate in any of the above high-risk activities that I will report this to the physician or nursing staff at Overlake Reproductive Health and that I may be asked to postpone the donation or possibly be excluded from the donor program or may disqualify cryopreserved embryos from being donated in the future. By participating in any high-risk activities such as those described in the Risk Factor Assessment, I understand that legal recourse by the recipient couple or individual receiving the

donation is possible should my actions cause any adverse effects. I agree to indemnify, defend and hold harmless Overlake Reproductive Health, its doctors and employees from any and all claims, losses, liabilities and demands suffered by any of them as a result of my participation in any high-risk activities or behavior and/or any untruthfulness or inaccuracy by me concerning the same.

I understand that my participation will be a contribution to the general advancement of medical knowledge and for the benefit of the recipients' suffering from infertility. I understand that I may terminate my participation as a donor at any time without prejudice to my medical care.

I agree not to hold Overlake Reproductive Health, its doctors or employees responsible for any injury or untoward events that may occur as a result of the oocyte donation. I have read the donor question and answer sheet and understand the known and potential risks of egg donation. I further understand that if any medical complications occur as a result of my participation in the donor egg program, I will be responsible for the costs of evaluation and treatment of such medical conditions. I understand that an insurance policy that will pay for such treatment as a result of egg donor procedure complications has been taken out in my name by the recipient, and is underwritten by AIG Life Insurance Company.

I understand that I will be compensated to defray expenses associated with this donation. I will receive half at the time of the egg retrieval and the remainder at my follow-up appointment.

_____ Donor's Name	_____ Donor's Signature	_____ Date
_____ Donor's Partner's Name	_____ Partner's Signature	_____ Date

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Street Address	City, State, Zip
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\_\_\_\_\_  
Telephone No.

_____ Witness' Name	_____ Witness' Signature	_____ Date
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I have volunteered to be an egg (ova) donor, which may include medical treatment for stimulation of production and the retrieval of my eggs, to be accomplished at Overlake Reproductive Health. I have reviewed a contract with Overlake Reproductive Health, which contract sets forth my rights and obligations as an egg donor.

I have been informed that I have the right to review the contract with an attorney of my choice before signing it, and I have further been told that if I request it, I will be given a list of attorneys who practice in the area of assisted reproduction.

I understand that the decision as to whether to consult with an attorney before entering into the donor contract is solely my decision.

I understand the provisions of the donor contract which I am entering into with Overlake Reproductive Health, and I choose to waive consultation with an attorney prior to signing the contract.

Dated: \_\_\_\_\_

Signed: \_\_\_\_\_

Social Security Number: \_\_\_\_\_