



CONSENT FOR EGG DONATION INTENDED PARENT(S)

I/We, _____ (intended parent) and _____ (partner/intended parent), wish to participate in the Oocyte Donation Program ("Egg Donation Program") offered by the California Center for Reproductive Health (CCRH). I/We wish to receive one or more donated oocytes ("eggs") as part of our attempt to establish pregnancy through in vitro fertilization (IVF). We realize that prior to participating in the Egg Donation Program, it is important to understand the proposed procedures, risks, benefits, treatment alternatives, and the social and legal considerations. Accordingly, our physician, Dr. Eliran Mor and/or Dr. Irene Woo, has explained to us, and we hereby acknowledge our understanding of the following:

Donated Ovum Procedural Overview

Due to our inability to produce normal eggs, pregnancy will be attempted using in vitro fertilization of donated egg(s) obtained from an anonymous egg donor or an egg donor known to us.

Eggs will be obtained from the donor however; there are no guarantees as to the number, quality, normality, or the fertilization capabilities of the retrieved eggs. The donated egg(s) will be fertilized in the laboratory with the sperm of the intended parent(s) or sperm donor, by either insemination (mixing of sperm with eggs) or intracytoplasmic sperm injection (ICSI: the injection of a single sperm into each egg). Fertilization will be confirmed, and if successful, the resulting embryos will be transferred to the intended parent's or designated gestational surrogate's (recipient's) uterus in accordance with the standard IVF practice. Cryopreservation (freezing) of some or all of the resulting embryos is a possibility.

The egg donation process will rely on the recipient having a normal endometrial cavity and uterine lining, and very close simulation of the normal process of ovulation with hormonal support. Estrogen and progesterone hormones will be administered orally, by injection, skin patch and/or by vaginal suppositories. Serial monitoring ultrasound and blood tests are necessary to determine if the recipient's uterus is receiving adequate hormonal support. These hormonal treatments must begin several weeks before embryo transfer is anticipated in order to mimic the normal menstrual cycle. In addition, supplemental hormone administration will be required to maintain the pregnancy during approximately the first three months.

General Considerations for Anonymous Egg Donation

If a pregnancy is established utilizing donated egg(s) from an anonymous donor, the child will not be genetically related to the female intended parent (if applicable). The Donor has been informed that she will not be provided with any information about our identities, the egg(s), the establishment of any pregnancy or any information of any type concerning the outcome of our treatment, unless we choose to release any such information.

General Considerations (Anonymous or Known Donors)

The ovum donor has signed a consent form stating that she has relinquished any and all rights to the donated egg(s), any resulting embryo(s), and to any child or children who may be born as a result of the egg donation. A copy of the consent form, identical to the one executed by our donor, is attached hereto. We understand that the donor of the eggs has undergone an extensive evaluation of personal and family medical and mental histories, including a psychosocial screening, genetic history and appropriate laboratory tests in an attempt to rule out any ongoing disease process, transmissible/inherited medical and genetic disease, or sexually-transmitted disease, and to determine blood type, and we have been given access to this information on a non-identifying basis. We also understand that it is impossible to rule out or guarantee against all ongoing disease processes, transmissible/inherited medical and genetic diseases, or sexually-transmitted diseases in the donor or resulting offspring from the egg donation process. The truthfulness of the donor cannot be guaranteed and the information provided is dependent on the donor's integrity and honesty. We recognize that it may be necessary to rely upon our physician's judgment and discretion as to the donated ovum and the appropriateness for implantation/transfer. We, however, have the ability to accept or reject any donor made available to us, based on our personal preference. The donor's participation in this program is voluntary, and the donor may choose to withdraw at any time.

We have been advised that we may request and will be provided with the following information, to the extent that it is known by our physician: the medical history of the donor, including but not limited to, any available genetic history, blood type, Rh factor, race, eye and hair color, height and weight, educational attainment and talents of the donor, religious background, and any other information that the donor has indicated may be disclosed. We acknowledge that the donor may request to withhold certain information, and we are entitled to know the nature of the withheld information without disclosure of details. Donor information is maintained for at least five (5) years following the procedure, and at the expiration of this period may be destroyed by the physician without further notice to us.



Fertilization, Transfer and Cryopreservation of Fertilized Eggs

These procedures will be performed by Dr. Eliran Mor or Dr. Irene Woo, and his/her assistants/associates acting under his/her direction at CCRH and its affiliate laboratory.

On or before the morning of the egg donor’s egg retrieval, a semen specimen will be provided by either:

_____ Partner/intended parent(s); or

_____ Sperm donor, obtained cryopreserved and quarantined from an accredited cryobank. (If married, a separate informed consent must be completed by the participants.) Our acceptance of donor sperm for insemination and/or ICSI of donor eggs, and the intended parent(s)’s intent to be recognized as the legal parent of any children resulting from egg donation/sperm donation is further evidenced by our signatures below:

SPERM DONOR #: _____ Cryobank: _____

_____ Intended Parent (Name/Signature)

_____ Partner/Intended Parent (Name/Signature)

We acknowledge that the number of retrieved eggs, their quality, and their fertilization potential is unpredictable. We understand that any non-viable (i.e. degenerating or abnormal appearing eggs), or immature eggs will be discarded, while an attempt will be made to fertilize all normal appearing/mature eggs into embryos, unless otherwise specified by us. We understand that not all eggs will fertilize and that abnormal fertilization is also possible. We further understand that not all normally fertilized eggs will develop into viable embryos. Subject to our doctor’s medical judgment and opinion, the following are our directives concerning the number of embryos to be transferred to the uterus, cryopreserved (frozen) or discarded:

A. We wish the number of eggs to be inseminated/ICSI’d:

- _____ a) to be limited to _____ eggs, and we understand that any remaining unfertilized eggs will be discarded, or
- _____ b) to be limited to _____ eggs, and we understand that any remaining unfertilized eggs will be frozen**, or
- _____ c) all eggs

**A separate Consent for Egg Freezing must be signed

B. We have been advised and accept the fact that transferring more than one embryo may substantially increase the risk of a multiple gestation, with additional risks to the pregnancy, fetuses, and the intended parent or gestational surrogate female recipient. We acknowledge that a small risk exists that a single embryo may “split” into an identical twin. We have further been advised that the risks of a higher order multiple gestation (triplet or more) carry significant risks to the children, including but not limited to, extreme prematurity (which may be associated with chronic respiratory problems, chronic gastrointestinal problems, hearing/visual impairment, learning disabilities...), miscarriage, low birth weight, birth defects, or death of one or more of the children; as well as significant health risks to the mother, including but not limited to, pregnancy induced hypertension, gestational diabetes, preterm labor, and maternal death. To substantially reduce the risk of multiple pregnancies beyond twin pregnancies, we have been advised that CCRH typically transfers no more than two (2) embryos unless specific, individual circumstances exist which will be discussed with us before any transfer.

C. If the number of fertilized eggs exceeds the number of embryos transferred, we will be offered the option of cryopreservation (freezing) of the excess embryos to allow transfer in a later cycle. All excess embryos not frozen will be discarded. A separate Consent for Cryopreservation of Embryos Agreement must be signed before any freezing can occur and we expressly recognize and accept that if we have not executed this Consent and Agreement, any excess embryos will be automatically discarded.

_____ Initials

Optional Procedures

A. Intracytoplasmic Sperm Injection (ICSI)

Intracytoplasmic sperm injection (ICSI) is a specialized assisted reproductive technique (ART) employed in the in vitro fertilization (IVF) laboratory whereby a single sperm is injected into an egg to achieve fertilization. The most common indication for ICSI is male factor (low quality sperm). However, other clinical situations such as unexplained infertility, poor prior fertilization in the IVF lab using standard fertilization techniques, and a low egg count are also common indications. On occasion, the quality of sperm on the day of egg retrieval may be found to be reduced despite no known male factor, prompting ICSI to be done in an effort to optimize fertilization of eggs. A separate Consent for Intracytoplasmic Sperm Injection must be signed before ICSI can be performed.

Our initials indicated that we consent to Intracytoplasmic Sperm Injection (ICSI) of egg(s):

Initials

B. Assisted Hatching

Assisted hatching (AH) is a specialized laboratory procedure whereby the shell surrounding the embryo, called the zona pellucida, is weakened using micromanipulation instruments in order to facilitate the hatching (release from its shell) of the embryo, so as to improve the chance of implantation in the uterus. Assisted hatching is commonly employed in cases of assisted reproductive techniques (ART) in which the female partner is older than 37 years of age, in couples with prior in vitro fertilization (IVF) implantation failure, when the zona pellucida is determined to be excessively thick, and in embryos who have previously been frozen. As egg donors are commonly under the age of 27, AH is infrequently performed in egg donation cycles, however other indications for AH may exist, as stated above. A separate Consent for Assisted Hatching must be signed before AH can be performed.

Our initials indicated that we consent to Assisted Hatching (AH) of our embryo(s):

Initials

C. Embryo Transfer

The embryo transfer will normally take place three (3) to five (5) days following egg retrieval. The embryo(s) transfer procedure requires no anesthesia and there is minimal to no discomfort. A speculum is inserted into the vagina to visualize the cervix (neck of the womb) and a small soft plastic tube (catheter) containing the embryo(s) is passed into the uterine cavity. The embryo(s) is then injected through the tube into the uterine cavity. This procedure will be performed by Dr. Mor or Dr. Woo, and his/her assistants, acting under his/her direction and control. A separate Consent for Embryo Transfer must be signed before the embryo transfer procedure.

Our initials indicated that we consent to Embryo Transfer of our embryo(s):

Initials

Risks and Benefits

If the procedure is successful, the benefit of undergoing IVF with a donated ovum will be pregnancy, which otherwise would have been unlikely.

There is a risk of transmission of disease from the donor to the resulting embryo(s) and/or female intended parent or gestational surrogate recipient. These diseases may include, but are not limited to, Cytomegalovirus (CMV), Hepatitis, Human T-Lymphotropic Virus (HTLV), and the Human Immunodeficiency Virus (HIV). Although the donor is tested and the risk of transmitting these diseases is believed to be minimal, the absence of any disease in the donated egg cannot be guaranteed, and we acknowledge and accept this risk. Furthermore, it may be difficult to test for the presence of certain types of viruses, such as CMV, with a high level of accuracy.

Media utilized for IVF and assisted reproductive techniques (ART) associated procedures (Assisted Hatching, Intracytoplasmic Sperm Injection, Embryo Transfer, etc.) may contain commercially obtained serum or serum components. While every effort to screen these products for hazards (e.g. HIV, Hepatitis, etc.) has been made, the potential for unforeseen hazards is present and hereby acknowledged.

We also understand that information concerning the long term effects of receiving donated egg(s) is limited and the consequences of the procedure, for us as intended parents or the child(ren), may not be fully understood at this time. We agree and consent to undergoing any medical, genetic, and/or psychological evaluation requested by the Egg Donation Program as a condition to our participation in the Egg Donation Program.

We understand that the purpose of the evaluation process is to help us identify diseases, genetic characteristics, psychological issues and other factors that may pose a significant medical or psychological risk to us as intended parents or to any child(ren) conceived. However, we acknowledge that despite such evaluations, CCRH cannot assure against the possibility of a disorder, handicap, health condition, or unwanted genetic trait in any child(ren) conceived through this procedure or that CCRH can fully guarantee the prevention of transmission of disease or infection from the donor or her male partner to the recipient (intended parent or gestational surrogate), recipient's partner, or child(ren). We acknowledge that CCRH has not given any guarantee or warranties to us as to the fitness of the donor's eggs or of the physical or mental characteristics of any resulting child(ren) and acknowledge that CCRH, or any individual associated therewith, will not be responsible for any adverse outcomes.

Some nonphysical risks of participation may include increased time commitments and travel considerations, financial implications, risks related to insurability and employment, and psychological effects.



Treatment Alternatives

Despite receiving the diagnosis of diminished ovarian reserve as one indication for egg donation, ovarian hyperstimulation and IVF may still be alternatives to egg donation for some intended parents. Additional alternatives to egg donation may be the implantation of donated embryo(s), gestational surrogacy combined with egg donation, adoption, or receiving no treatment for infertility.

Social & Legal Considerations

Because the legal issues of parentage for children born through ovum donation are not settled and because of legal uncertainties related to the field of infertility, you are encouraged discuss the information contained in this informed consent with an attorney before proceeding. The Egg Donation Program at CCRH requires that a legal agreement be signed between the intended parent(s) and the egg donor. This informed consent is not legal advice and does not constitute an assurance that the intended parent(s) will be recognized as the legal parent(s) of any resulting child.

As the intended parent(s), we understand and acknowledge our obligation to care for and support any child(ren) born as the result of receiving embryos conceived from donor eggs. The child shall be the lawful child of the intended parent(s).

Financial Considerations, Expenses, & Costs

We understand that insurance coverage for any and all of the infertility procedures may or may not be available, and that we will be personally responsible for all of the expenses associated with our treatment for infertility and donated ovum and embryo transfer, including the costs and compensation associated with the ovum donor's participation. These expenses may consist of, but are not limited to, hospital and laboratory charges and professional fees. We understand that if the Donor has acknowledged she has health insurance, CCRH assumes no responsibility for independently verifying such coverage.

Information regarding any specific anticipated treatment expenses and anticipated fees for the egg donation cycle will be further discussed prior to the initiation of any treatment, and the financial support outlined for the donor will be provided to us at that time.

Initials

Certification and Acknowledgement of Informed Consent & Authorization to be Egg Donation Intended Parent(s)

We have read and understand all information contained in this form and we voluntarily consent to receive a donated ovum in hopes of having a child. We understand and accept the fact that there is no guarantee of success of implantation, or for a successful, normal pregnancy. We acknowledge and understand that our physician, our physician's staff, and CCRH cannot be responsible for the physical or mental characteristics or for any abnormality of any child conceived through the use of a donated ovum and implanted by IVF. We understand that our participation is voluntary and that we can withdraw from the Egg Donation Program at any time without affecting the availability of other or future medical care, and with the knowledge that we will continue to receive quality, ongoing medical care at our request.

We have had the opportunity to ask all questions we may have had about the Egg Donation Program and in vitro fertilization, and those questions have been answered to our satisfaction. Dr. Mor and/or Dr. Woo has explained the procedure, the risks, benefits, and treatment alternatives to us, as outlined in this informed consent. We have carefully, thoroughly, and voluntarily considered this decision, and our signature indicates our informed consent to proceed with the treatment. In the event that we have additional questions concerning any aspect of this procedure, we can contact Dr. Mor and/or Dr. Woo.

PATIENT NAME (print)

PATIENT SIGNATURE

DATE

PARTNER NAME (print)

PARTNER SIGNATURE

DATE

WITNESS (print)

WITNESS SIGNATURE

DATE