



**Patient Information
For
Egg Donors
And
Donor Egg Recipients**

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



EGG DONOR PROGRAM

Table of Contents

- 1. Introductory Letter(s)**
- 2. General Information**
- 3. Prospective Egg Donor Information**
- 4. Consent Forms**
- 5. Contact Information**
- 6. Additional Resources**

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...Exceeding patient expectations...”



Section 1

Introductory Letter

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



Dear Patient,

Thank you for your inquiry into our egg donor program. Enclosed you will find information on egg donation, which explains our program in detail. This is for you to review and to keep for your records.

For Perspective Recipients:

We are honored you have chosen our program at Advanced Reproductive Health Centers, Ltd. Years of experience combined with our caring attention should make your experience as stress free as possible.

For Perspective Egg Donors:

In this material you will find a questionnaire entitled **Prospective Oocyte Donor Questionnaire**. After reviewing the information, please complete this form and return it to our office with a recent photograph of yourself. This photograph is for our use only and will assist us to match you with a donor recipient. Your inquiry will be kept confidential.

Once we have received your questionnaire and photo, your medical information will be reviewed. If you appear to be an appropriate match for one of our recipient couples, our office will call you to schedule an appointment to meet with one of our physicians, myself and to start your screening tests.

Thank you again for your interest in our donor program. Your donation would be a precious gift to an infertile couple whose only chance of conceiving is through the voluntary efforts of an egg donor.

Please feel free to call me with questions at 1-866-IVF-CHGO.

Sincerely,

Cheryl Tropsic
Coordinator
Donor Egg Program

Our Mission Statement: “...Exceeding patient expectations...”
www.Chicago-IVF.com



Section 2

General Egg Donation Information

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD
CHICAGO IVF**

Information for Prospective Egg Donors

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



Advanced Reproductive Health Center, Ltd. Oocyte Donation Program

Donor Letter

Dear Prospective Donor:

We at Advanced Reproductive Health Center Ltd. would like to take this opportunity to thank you for your recent interest into the Oocyte Donation Program. Enclosed you will find information to assist you in the decision whether you would like to pursue the possibility of becoming an egg donor.

In the literature enclosed, we discuss several issues surrounding the whole process of egg donation, and briefly how the process takes place.

Oocyte Donation can benefit three groups of patients suffering from the following difficulties related to the inability to produce a pregnancy:

- 1. Premature Ovarian Failure (Early Menopause)**
- 2. Occult Ovarian Failure**
- 3. Advanced Maternal Age**

Premature Ovarian Failure occurs in women under the age of 40 whom for a variety of reasons have entered into menopause at an early age.

Occult Ovarian Failure occurs in women who still have monthly periods but whose eggs are for some reason unable to conceive. This group makes up the largest group of women needing egg donation.

Advanced Maternal Age may inhibit a woman's egg from conceiving due to the increased age of her eggs. By retrieving eggs obtained from younger women, they can experience the joy of carrying and delivering a child.

Steps for Egg Donation

- 1. Completed Application**
- 2. Physical Exam and Laboratory Clearance**
- 3. Acceptance into Program**
- 4. Donor/Recipient Match**
- 5. Injectable medication to suppress ovarian function**
- 6. Injectable medication known as fertility medications**
- 7. Monitoring of ovaries by ultrasounds and lab work**

8. Retrieval of eggs once maturing is complete

The ideal donor is typically a reliable woman interested in helping women overcoming their infertility. It is preferable that a donor already has children without a history of infertility herself.

CONFIDENTIALITY

The majority of donors remain anonymous. Which means both the recipient and the donor does not meet or know each other. While the recipient might choose a “known donor” (e.g. a sister or friend).

COMPENSATION

Donors are considered as volunteers, but are compensated for their time and effort devoted to this endeavor. Please contact Cheryl Tropsic the Egg Donation Coordinator at 1-866-IVF-CHGO for the current compensation per completed cycle.

QUESTIONS

Questions can be addressed to the Egg Donation Coordinator, Cheryl Tropsic at 1-866-IVF-CHGO. Once the application has been returned and reviewed, you then will be contacted to schedule an appointment for a brief physical exam and necessary screening blood work. If all preliminary testing is acceptable, you will be notified of your acceptance and entered into the Advanced Reproductive Health Center, Ltd. Oocyte Donation Program.

Sincerely,

Cheryl Tropsic
Egg Donation Coordinator

www.Chicago-IVF.com

1-866-IVF-CHGO

Our Mission Statement: “...Exceeding patient expectations...”



Egg Donor Booklet

INTRODUCTION

This booklet has been written for those who are going to donate their oocytes (eggs) to an infertile couple at Advanced Reproductive Health Centers, Ltd. The aim of this booklet is to take you step-by-step through the process of egg donation, explain why certain things are done and answer most of the questions that commonly arise during treatment.

We suggest that you read this booklet carefully and refer to it often during your treatment cycle. If you are unclear about any aspect of your treatment, please do not hesitate to ask one of our staff members. We are always happy to assist and answer any of your questions.

WHO NEEDS DONATED EGGS?

Egg donation has become an integral part in the management of infertility for those women who were previously considered to be unable to conceive. Women who are unable to produce or use their own eggs require donated eggs. The following are some examples of why a woman would need donated eggs:

- Premature ovarian failure
- Poor ovarian response to stimulation medications
- Absence of the ovaries
- Carriers of a genetic disorder
- Ovarian failure due to a chemotherapy and/or radiation treatment

WHAT KIND OF PEOPLE DONATE EGGS?

Women donate their eggs for many different reasons. In most cases, there is a compensation for their time. Anonymous egg donation is preferred but known donors are considered. The donor must be between the ages of 21-32 and healthy.

A careful medical, psychological, genetic and family history is taken from the potential donors. All donors undergo hormonal testing, blood and cultures for sexually transmitted diseases, and drug use.

All donors are asked to meet with a counselor. After the screening process is completed, the IVF staff reviews the chart. The decision is then made to proceed with the donor. Egg donors have no continuing responsibility to any child born following egg donation.

HOW ARE DONORS MATCHED WITH RECIPIENTS?

Recipients are asked what characteristics are important when choosing a donor. These usually include physical characteristics such as hair color, eye color, height, weight, build, complexion, race, blood type and family medical background. All matched are confidential. A number system is used to maintain anonymity.

OVARIAN STIMULATION

The ovaries must be stimulated in order to produce multiple eggs and therefore increase the chances of conception. This is termed *controlled ovarian hyperstimulation* and can be initiated by the use of drugs that mimic the action of the body's natural hormones.

Drug doses are individualized for each patient depending on a number of factors including age, medical history, body size, hormonal levels, etc. Each patient will be given exact instructions prior to starting treatment.

MEDICATIONS AND SIDE EFFECTS

The following is a list of medications commonly prescribed by the physicians at Advanced Reproductive Health Center, Ltd. with a brief description of each. Individual dosages will be determined by your physician and will be discussed with you prior to treatment.

LUPRON

Lupron suppresses the ovaries by "slowing down" the activity of the pituitary gland. It is given by injection under the skin (subcutaneous).

Possible side effects include headaches, hot flashes, mild skin irritation or bruising.

GONADOTROPINS – Repronex, Fertinex, Gonal-F or Follistim

These drugs are administered by intramuscular (IM) or subcutaneous (SQ) injection. Their action is to stimulate follicular development. They are given as a daily injection.

Possible side effects include: allergic type reaction- rash, swelling, or pain at the injection site can occur. If a local reaction does occur, the site of the injection should be changed. If the reaction is severe, contact the ARHC staff immediately. Fever and joint pain are uncommon. If you do experience any of these symptoms, you **MUST** contact the ARHC staff immediately. Other possible side effects include an increase in cervical mucus, lower abdominal pain and discomfort, and painful intercourse.

Although major side effects are uncommon, ovarian hyperstimulation syndrome (OHSS) can occur if there is an over response of the ovaries to the gonadotropins. This may cause abdominal pain, vomiting, abdominal distention, and shortness of breath. It usually

presents in the later stages of the treatment cycle after egg retrieval. If it does develop, hospitalization could be required. When monitoring during the treatment cycle, if we suspect that there is a significant risk of OHSS developing, it is often better to abandon the cycle. *Additionally, when stimulation of the ovaries begins, it is important to abstain from sexual intercourse. The reason for this is that you will be potentially very fertile during the stimulation phase.*

HUMAN CHORIONIC GONADOTROPIN

This drug, administered as a single IM injection, is used to finalize the process of egg maturation. It is usually given 34-36 hours before the egg retrieval. *It is very important that you have the injection at the given time instructed by your coordinator. It is vital to a successful retrieval.*

Possible side effects include headache or local reaction.

Other drugs may be given during your treatment cycle. Your physician or IVF coordinator will explain any additional medications to you.

MONITORING YOUR TREATMENT

All monitoring is done in the early morning at each of our satellite offices. Monitoring consists of blood tests and ultrasound to determine the development of the follicles. Please schedule these appointments with the front desk staff. You will be called each afternoon with medication instructions and further follow up.

You must continue administration of your medications until you are told to stop by a member of the medical staff (usually on the day of the HCG administration).

PREPARING FOR YOUR EGG RETRIEVAL

When follicle size and hormone levels are appropriate, you will be instructed to take your injection of HCG. *Again, it is imperative that you take this injection at the time you are told.* You will be given clear instructions on the day and time of your injection.

DAY OF EGG RETRIEVAL

On the day of your retrieval, you will be asked to **arrive one hour prior to the time of your procedure.** You will have a brief consult with the nurse anesthetist prior to the procedure to go over your sedation. **You will be required not to eat or drink anything after midnight the night before your retrieval.**

Eggs are recovered vaginally, using the ultrasound probe to guide a needle to aspirate the follicles to obtain the eggs. You can expect to be at ARHC approximately 3-4 hours. During the post-operative period, you may experience some abdominal discomfort

similar to “period” pain. You will be given instructions regarding pain relief upon discharge.

You must have someone pick you up and drive you home after the procedure is completed. We advise that you go home and rest the remainder of the day. Please be advised to abstain from sexual intercourse until you have your period since you are at a higher risk to conceive. You may experience some vaginal bleeding. This should subside after a few hours.

If for any reason you experience severe abdominal pain, prolonged bleeding, feel faint, excessive bloating, vomiting or shortness of breath, you must contact ARHC as soon as possible.

WHERE PROBLEMS OCCUR

Described below are some potential problems that may occur during your treatment cycle:

If there are a low number of follicles being produced, the cycle may be cancelled. We would then evaluate the cycle and make suggestions for improvement for future cycles.

If there are an extreme number of follicles and high hormone levels, the cycle may be canceled due to the risk of ovarian hyperstimulation syndrome.

Not all of the follicles contain eggs, and not all eggs may be mature (usable). Rarely, no eggs are recovered or all eggs are abnormal.

COUNSELLING AND SUPPORT

Before you are accepted into the program, you are asked to meet with a counselor. We provide this counselor to you at no charge. This is an opportunity to consider whether you want to proceed and also a time to ask questions and clarify for yourself what donation will actually mean for you, your partner and your family. Important areas need to be explored such as the boundaries of your own responsibility as a donor.

PAYMENT

You will receive a check on the day of your retrieval for your time and energy. The recipients and the staff of ARHC truly appreciate this gift you have given.



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD
CHICAGO IVF**

Information for Prospective Donor Egg Recipient

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”

INTRODUCTION

This booklet has been written to provide information to couples undergoing egg donation. The booklet aims to take you step-by-step through the treatment cycle and will provide you with answers to many questions you may have.

We suggest that you read the booklet carefully and refer to it often during your treatment. If you ever have any questions that may not be addressed in this booklet, our medical and nursing staff is always happy to assist you.

WHO NEEDS DONOR EGGS?

Egg donation has become an integral part in the management of infertility for those women who were previously considered to be unable to conceive. Women who are unable to produce or use their own eggs require donated eggs. The following are some examples of why women would need donated eggs:

- Premature ovarian failure
- Poor ovarian response to stimulation medications
- Absence of the ovaries
- Carriers of a genetic disorder
- Ovarian failure due to chemotherapy and/or radiation treatment

WHAT KIND OF PEOPLE DONATE EGGS?

Women donate their eggs for many different reasons. Advanced Reproductive Health Centers, Ltd., has strict criteria that donors must possess before the program considers them. They must be between the ages of 21-32 and healthy. A careful medical, psychological, genetic and family history is taken from the potential donor. They undergo hormonal testing, blood and cultures for sexually transmitted diseases, and drug use. All donors undergo mandatory screening by our staff psychologist. **Egg donors have no continuing responsibility to any child born following egg donation.**

HOW ARE DONORS MATCHED WITH RECIPIENTS?

Recipients are asked what characteristics are important to them when choosing a donor. These usually include physical characteristics such as hair color, eye color, height, weight, build, complexion, race, blood type, and family medical background. **All matches are confidential. A number system is used to maintain anonymity.**

SYNCHRONIZING OF DONOR AND RECIPIENT CYCLES.

The most important step in the egg donation process is the synchronization of the ovarian cycles of both the donor and the recipient. This ensures that the embryos are placed in the recipient's womb at the optimal time for implantation. This is achieved by the use of birth control pills and Lupron, which makes the ovaries inactive.

When both the donor and recipient's cycles are regulated, the donor begins fertility medications to stimulate her ovaries to produce eggs. The recipient will then start her regimen of estrace. This medication will enhance the lining of the uterus so it will be well prepared to receive embryos.

When the donor's follicles are of the correct size, and the hormone levels are appropriate, she will be given an injection of Human Chorionic Gonadotropin (HCG) to ensure final maturation of the eggs. The eggs are retrieved 36 hours later by transvaginal ultrasound guided needle aspiration at our office in Orland Park, under anesthesia.

The day the donor has her retrieval; the recipient starts progesterone supplementation to ensure the lining of her uterus is well prepared to receive the embryos.

The eggs are fertilized in the manner that offers the best chance of success. The method of fertilization is agreed upon and consented by the couple prior to the insemination taking place.

Three days following the retrieval, the embryos are placed into the recipient's uterus. The number of embryos replaced will be the decision of the couple and their physician. If there is a surplus of embryos and they are of sufficient quality to freeze, we can do so at an additional fee to the recipients.

WHAT GUARANTEES ARE THERE WITH THE DONOR?

Women volunteer to donate their eggs and for the most part are well motivated and committed to completing the process. It is however, completely within their right to withdraw from treatment at any given time up until egg retrieval.

There may be times where the donor responds poorly and does not produce enough follicles or stimulates too quickly. In either of these instances, the cycle may be canceled due to poor donor response or the risk of severe ovarian hyperstimulation.

MEDICATION AND SIDE EFFECTS

The following is a list of medications commonly prescribed by the physicians of Advanced Reproductive Health Center, Ltd., with a brief description of each. Individual dosages will be determined by your physician and will be discussed with you and the donor prior to treatment.

It is imperative that each patient understands her dosage and means of administration prior to starting the medication. You will be provided with the opportunity to sit down with a nurse for shot training and medication teaching.

LUPRON

Lupron suppresses the ovaries by “slowing down” the activity of the pituitary gland. It is given by injection under the skin (subcutaneous).

Possible side effects include headaches, hot flashes, mild skin irritation or bruising.

ESTROGEN

Recipients receive a natural estrogen replacement that is used to thicken the endometrium (the lining of the uterus) in order to prepare for implantation of the embryos.

PROGESTERONE

Progesterone is used to support the lining of the uterus in preparation for the developing embryo. It is given as an intramuscular injection.

Possible side effects include weight gain, gastrointestinal disorders and breast discomfort. Local reaction at the injection site may occur.

Other drugs may be given during your treatment cycle. Your physician or IVF coordinator will explain any additional medications to you.

MONITORING YOUR TREATMENT

All monitoring is done in the early morning at each of our satellite offices. Monitoring consists of blood tests and ultrasounds to determine the development of the endometrial lining as it prepares for implantation of the embryos. Please schedule these appointments with the front desk. You will be called each afternoon with medication instructions and further follow up.

OOCYTE (EGG) RETRIEVAL

Please note that your partner will have to be in our Orland Park office the day of the recipient's retrieval in order to give a semen sample at a given time. He should not leave until the embryologist has given the okay.

FERTILIZATION

Eggs and sperm are cultured overnight and checked the following morning for fertilization. The embryologist will call you the following day and let you know about the developing embryos. If fertilization does not occur, you will meet with your physician to discuss future options.

EMBRYO TRANSFER

Three days after fertilization, the embryos are ready to be transferred to the recipient's uterus. You will be advised by the IVF team of the date and time of the transfer.

Your procedure will take place at our Orland Park office and you will not be under anesthesia as this is not a painful procedure. A speculum is placed into the vagina and the cervix is exposed and cleaned. The embryos are then drawn up into the catheter, which is then carefully and gently inserted through the cervix into the uterus. After the transfer, the embryologist will examine the catheter under the microscope to make certain that no embryo(s) were retained in the catheter. After the transfer is complete, you will stay in the office for one hour and be advised to remain on bed rest for the following two days.

AFTER THE EMBRYO TRANSFER

All patients will take a progesterone supplementation until their first pregnancy test. Following a positive pregnancy test, you will remain on progesterone and estrogen until approximately the 11th or 12th week of pregnancy. If the test is negative, you may discontinue progesterone. You can expect to get a period within two weeks.

It is not unusual to have slight vaginal bleeding after your transfer. **DO NOT** stop your progesterone, and call the office if this happens. Abdominal discomfort is also common the second half of the cycle.

EMBRYO FREEZING

You will be asked to sign a consent regarding your desire for embryo freezing. Please note: not all embryos are of suitable quality to freeze, and not all survive the freezing and thawing process.

PAYMENT

It is the policy of Advanced Reproductive Health Centers, Ltd./Chicago IVF that full payment is made prior to the donor starting any medications. Please contact our financial office for details and payment options.

CHECKLIST FOR MALE PATIENT

1. Male ART panel with our embryologist. This includes a semen analysis, anti-sperm antibodies sperm freezing, and any additional tests that the embryologist may deem necessary. This is usually one specimen that must be produced one hour prior to testing. Please also be aware that there should be at least 2 days but no longer than one week of abstinence before collecting the specimen.
2. Blood test for HIV, Hepatitis A, B, & C and RPR within the last year.
3. All consent forms must be signed and in the chart.

CHECKLIST FOR FEMALE PATIENT (Please ask for a copy of current American Society Reproductive Medicine Screening Guidelines, we follow the ASRM guidelines).

1. Blood test for HIV, Hepatitis A, B, C, Chlamydia, RPR
2. Blood type, thyroid testing, prolactin, rubella, and recent day 3 labs.
3. Recent HSG or Sonohysterogram.
4. Trial transfer by transferring physician.
5. All consent forms signed and in the chart.

All couples are required to meet with their physician and our psychologist prior to beginning their treatment cycle.

WHERE PROBLEMS OCCUR:

It is very important that you understand the treatment cycle is highly complex. It is important that you understand your chance of success that your doctor will discuss with you.

Described below are some potential problems you should be aware of before beginning treatment.

The Donors Monitoring Phase

If there are a low number of follicles being produced, the donors cycle may be canceled. We would then evaluate the cycle and make suggestions for improvement for future cycles.

If there are an extreme number of follicles and high hormone levels, the cycle may be canceled due to the risk of ovarian hyperstimulation syndrome. Again the cycle would be evaluated and changes made for future cycles.

Egg Retrieval

Not all follicles will contain eggs, and not all eggs may be mature (usable). Rarely, no eggs are recovered or all eggs are abnormal.

Fertilization (Day after retrieval)

No fertilization can occur but is rare in couples with no identifiable male factor. It is however, more common when there is a proven sperm factor. This may also occur even if donor sperm is being used.

The embryos may also fail to cleave or divide normally. They may not be suitable for transfer.

AFTER A SUCCESSFUL TRANSFER

Negative Pregnancy Test: In spite of all the technical advances of the past few years, this is still sadly a possible outcome of a treatment cycle. Invariably, we have no explanation for why a cycle is not successful.

Pregnancy: It is important to realize that even if pregnancy does occur, problems can still arise. Miscarriages and ectopic pregnancies can occur. Congenital abnormalities are no more common than in natural conceptions.

Multiple Pregnancy: The chance of multiples increases with the number of embryos transferred to the uterus. Your doctor will discuss with you the possible complications of

multiple pregnancies including pre-term labor, premature birth, and increased financial responsibility.

COUNSELLING AND SUPPORT

Whatever the outcome of your treatment, the Advanced Reproductive Health Center staff aims to provide the maximum professional expertise, advice, and support to every couple. Following every cycle, our IVF team meets to review all of the cases to discuss any aspects of past or future treatment.

We are very aware of the stress involved in a treatment cycle and recommend **Dr. Howard Weissman**, our staff psychologist who specializes in infertility as a support person in addition to our staff. You can contact him directly for an appointment by calling (708) 403-4210.



Section 3

Prospective Oocyte Donor Questionnaire

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



Advanced Reproductive Health Center, Ltd. Oocyte Donation Program

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake)

Personal Information

Name: _____ Age _____ Date of Birth ___ / ___ / ___

Address: _____

Phone: (Home) _____ (Work) _____

I heard about the donor egg program at Advanced Reproductive Health Center, Ltd.
from:

___ A Friend

___ An ARHC patient

___ Another Donor

___ A newspaper/magazine add

___ Website

___ At ARHC

Education

___ High School Date of completion ___ / ___ / ___

___ College Date of completion ___ / ___ / ___

Current Major _____

Degree Obtained _____

___ Other

Employment

___ I am currently employed

___ Part-time employee

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake, Page 2)

Employment (continued)

___ Full-time employee

Occupation _____

___ I work in the home

___ I am unemployed

Marital Status

___ Married

___ Single with one partner

___ Engaged

___ Single and dating

___ Living together

___ Separated or Divorced

Sexual Preference

___ Heterosexual

___ Homosexual

___ Bisexual

Menstrual Cycles

Age when you had your first period? _____

I have a period every _____ days and it lasts for _____ # of days.

___ There are times that I have bleeding between my periods.

___ I have had bleeding after intercourse.

Sexual/Contraceptive History

I have had _____ sexual partners in the past year.

I currently have or have had in the past a sexual partner that has used drugs _____

I currently have or have had in the past a sexual partner that has a sexually transmitted disease _____

I currently have or have had in the past a sexual partner who is/was a homosexual or bisexual _____

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake, Page 3)

Sexual/Contraceptive History (continued)

For contraceptive use, presently I use:

____ Oral Contraceptives ____ Condom ____ IUD ____ Diaphragm
____ Depo-Provera ____ Norplant (If Norplant, date of last shot ___/___/___)

I have been treated in the past or have been told that I have been exposed to the following:

____ A sexually transmitted disease (Check all that apply)

____ Chlamydia ____ AIDS/HIV ____ Herpes

____ Venereal Warts ____ Syphilis ____ Gonorrhea

____ Endometriosis

____ PID

____ Ovarian Cysts

____ Tuberculosis

____ Abnormal Pap Smear

Pregnancy History

Please list all confirmed pregnancies with outcomes below:

Pregnancy	Did you deliver a baby?	If Yes, Boy or Girl and DOB	Does the child have any medical problems?	If No, Miscarry or Abortion?

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake, Page 4)

Psychological History

_____ I have been seen or treated by a psychologist.

_____ I have been diagnosed with one of the following currently or in the past:

_____ Depression _____ Obsessive-Compulsive Disorder

_____ Schizophrenia _____ Manic Depressive Disorder

_____ To my knowledge, no one in my family has ever been treated for the above problems.

_____ I have had family members treated with the above disorders

Please explain _____

Family History

Age (or Age at Time of Death)	Cause of Death	Height	Weight	Hair Color	Eye color	Medical Problems
Mother						
Grandfather						
Grandmother						
Father						
Grandfather						
Grandmother						
Brother/Sister						
Brother/Sister						
Brother/Sister						

I AM INTERESTED IN BECOMING AN EGG DONOR BECAUSE:

_____ I think it would be a rewarding experience for me.

_____ I always wanted to help someone with infertility difficulties.

_____ I think the process is exciting.

_____ I need the money.

_____ Other

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake, Page 5)

I WOULD BE AVAILABLE TO START TREATMENT BEGINNING ___/___/___

Certification

I hereby certify my answers were voluntarily given in this questionnaire. I have answered these questions to the best of my ability. I am not aware of any problems in myself, my family or previous sexual partners that have not been addressed in this questionnaire.

Signature

Date

Director Approval _____

Date _____

Physician Approval _____

Date _____



Advanced Reproductive Health Center, Ltd. Oocyte Donation Program

Oocyte Donor Profile Information for Recipient

Age: _____ Race: _____ #Times Pregnant _____

Ethnic Background (Your family's Country (ies) of origin):

- 1. _____ % *Example 1. Polish 50%*
- 2. _____ % *2. German 25%*
- 3. _____ % *3. Irish 25%*

Religion: _____ Occupation: _____

Education: _____ Eye color: _____

Skin Color: _____ Light _____ Dark _____ Medium Hair color: _____

Height: _____ Ft _____ In Weight: _____ Pounds

Frame: _____ Small _____ Medium _____ Large

Complexion: _____

Hobbies/Sports: _____

Tell something about yourself that you would like the perspective recipient of your eggs to know:

Don't forget to attach a current picture of yourself



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD
CHICAGO IVF**

PROSPECTIVE EGG DONOR:

Please return your profile to Cheryl Tropsic at:

**Advanced Reproductive Health Center/Chicago IVF
Attention: Cheryl Tropsic
5225 Old Orchard Road
Suite 10
Skokie, Illinois 60077**

Thank you.

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...Exceeding patient expectations...”



Section 4

Consent To Receive Donor Eggs In Assisted Reproductive Technology

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...Exceeding patient expectations...”



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD.
CONSENT TO RECEIVE DONOR EGGS IN ASSISTED REPRODUCTIVE TECHNOLOGY**

1. We, _____ (hereafter “Husband”) and _____ (hereafter “Wife”) in conjunction with the medical services provided at Advanced Reproductive Health Centers, Ltd. (hereafter “ARHC”) and in connection with our assisted reproductive technology treatment, desire to utilize eggs donated by a woman (hereafter “Donor”) other than the Wife.
2. As part of our treatment by the assisted reproductive technology medical staff of ARHC, we authorize the use of eggs donated by a Donor.
3. We have been informed that the Donor will be treated with fertility drugs, monitored with ultrasound equipment and will have eggs removed surgically either by laparoscopic or ultrasound direct follicle aspiration. We have also been informed, consent and agree that the assisted reproductive technology medical staff of ARHC will attempt to fertilize some or all of the donated eggs with sperm collected from the Husband or with donated sperm.
4. We have been informed, consent and agree that the use of freshly collected Donor eggs creates a possibility of transmission of infectious disease to any child born as a result of the procedures as well as to the Wife. We have been informed that the Donor will be screened for infectious diseases prior to egg donation but that such screening does not completely eliminate the risk of infectious disease transmission.
5. We have been informed, consent and agree that if fertilization occurs and embryo development takes place, the embryo(s) will be transferred to the uterus of the Wife. We also have been informed and understand that; (a) transfer of one or more embryos may not result in the Wife’s pregnancy; (b) if the Wife’s pregnancy does result from embryo transfer, the pregnancy may not be full term; (c) any pregnancy of the Wife includes possibilities of complications during childbirth; (d) any child born as a result of the pregnancy may be abnormal or a child may be born with undesirable tendencies; and (e) there may be other adverse consequences to the Wife or the child.
6. We also have been informed that other risks, complications and side effects may result from the use of the Donor’s eggs in connection with assisted reproductive technologies. We have been given the opportunity to ask questions about the procedures, methods being used and the risks and hazards involved and we believe we have sufficient information to give this informed consent. We have also discussed alternative treatments with the assisted reproductive technology medical staff of ARHC and it is our decision to accept the risks.

Consent to Receive Donors – Page 2

7. We agree to rely upon the discretion of the assisted reproductive technology medical staff in the selection of qualified Donors. We agree that the identity of the Donor will not be revealed to us unless we make use of the designated donor listed here: _____

8. There are risk factors associated with egg donation which include: (a) oocytes may not be obtained from the Donor; (b) the oocytes that are retrieved may not be normal; (c) the Husband may be unable to provide a semen sample; (d) fertilization may not occur; (e) cleavage or cell division may not occur; (f) the embryo(s) may not develop normally; and (g) implementation of the embryo(s) into the wall of the uterus may not occur.

9. We have been informed and understand that use of drugs such as Lupron and hormone replacement with estrogen and progesterone include risks, including the discomfort associated with the use of intra-muscular progesterone. We further have been informed, understand and consent to the risk that the embryo transfer may result in bleeding, infection and damage to the uterus, bowel or bladder.

10. We have been informed and understand that if in the exercise of reasonable judgment the embryologists and physicians of ARHC determine that any embryo(s) are non-viable or otherwise medically unsuitable for use for embryo(s) transfer, the embryo(s) shall be disposed of in accordance with ARHC policies and in a manner consistent with professional ethical standards and applicable legal requirements.

11. We agree that we are responsible for any costs and expenses associated with the selection, screening and treatment of the Donor in connection with the egg donation and retrieval, and compensation to the Donor for her expense, inconvenience, risk and discomfort as a result of participation in the egg donation as well as the costs of embryo transfer, embryo freezing and embryo storage. We hereby indemnify and hold harmless ARHC, its officers, directors, shareholders and employees from any medical and hospital expenses of the Donor arising from any medical complication in connection with the donation of eggs. Further, we have been informed and agree that if the Donor is unable to go through retrieval through no fault of her own, the Donor will be compensated according to a sliding scale based on the time involved in the treatment cycle and risk exposure.

12. We agree to purchase, at our own expense, “Donor Egg Insurance” for our donor egg cycle. ARHC, Ltd. may or may not arrange for such third party insurance. If ARHC, Ltd. does arrange for this insurance, we will pay for this insurance in advance. We have been offered a copy of the insurance policy and given contact information in the event we choose to speak directly with the insurance agent.

13. We agree that any child born as a result of our own participation in assisted reproductive technology procedures is a child conceived by our acts and hereby acknowledge that such child is our legitimate child with all the rights and privileges accompanying such status.

Consent to Receive Donors – Page 3

Signature

Signature

Dated: _____

Dated: _____

I, _____, one of the members of the assisted reproductive technology medical staff of ARHC by this signature state that the forgoing Consent was read, discussed and signed in my presence.

Dated: _____

Signature _____

www.Chicago-IVF.com
1-866-IVF-CHGO

Our Mission Statement: “...Exceeding patient expectations...”



Section 4

Consent To Donate Eggs

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD.
CONSENT TO DONATE EGGS**

(1) I, _____, voluntarily consent and agree to provide my services as a donor of eggs that will be used in connection with assisted reproductive technology procedures carried on at Advanced Reproductive Health Centers, Ltd. (“ARHC”).

(2) I consent to be: treated with fertility drugs to assist me in ovulation; monitored frequently using ultrasound to determine development of ovulation; tested frequently for serum (blood) hormone concentration; and, subjected to such other procedures as the members of the assisted reproductive technology medical staff of ARHC determine are appropriate and are subsequently consented to by me. I have also been advised, consent and agree that eggs will be obtained from me surgically by laparoscopic or ultrasound directed follicle aspiration when my ovulation process is at the appropriate stage as determined by the assisted reproductive technology medical staff of ARHC.

(3) I have been informed, consent and agree that the eggs obtained from me will then be donated to a recipient selected by the assisted reproductive technology medical staff of ARHC to be used for the purpose of attempting to establish a pregnancy. I have been informed, consent and agree that the assisted reproductive technology medical staff will attempt to fertilize these eggs with sperm from the recipient’s male partner or with donated sperm. I have been informed, consent and agree that if fertilization occurs and embryonic development begins, the embryos produced will be transferred to the uterus of the female recipient.

(4) I have been informed, consent and agree 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. I have been informed, consent and agree that from the moment of retrieval of the eggs, the eggs shall belong to the recipient and that the recipient shall have the sole and exclusive right to determine any medical procedures and treatment regarding the eggs and the recipient. If there are embryos generated in excess of what is safe to transfer to the recipient’s uterus at a single time, then the disposition of those embryos will be determined by the recipient. They may be frozen for the recipient’s future use or disposed of. I have been informed, consent and agree that the identity of the recipients shall not be disclosed to me unless I have donated eggs for use only by the couple named as follows: _____.

(5) Anonymous donors only: I have been informed, consent and agree that my identity will not be disclosed to the recipient couple. Likewise, I will not be given any information about the identity of the recipients. I have been informed that in certain cases, for medical reasons, it may be necessary for a recipient couple to seek certain

Consent to Donate Eggs– Page 2

medical information about myself or my family after completion of the cycle. I authorize the assisted reproductive technology medical staff to contact me in the future to ascertain this information. I understand that my anonymity will be maintained.

(6) I consent to a physical examination, including taking blood and other body fluids, as well as a test for exposure to the HIV (AIDS) virus, drug screening, genetic testing and psychological screening for the purpose of giving the assisted reproductive technology medical staff sufficient information to determine whether I am an acceptable egg donor. I have been informed of the potential risks of egg donation and have been given ample opportunity to have my questions answered.

(7) Risks of egg donation include:

- Overstimulation of ovaries, which could result in a feeling of bloating or abdominal discomfort.
- Risks associated with general anesthesia if used in connection with egg retrieval.
- Discomfort, infection and bleeding from laparoscopic or vaginal ultrasound recovery of eggs.
- Pregnancy or multiple pregnancies resulting from having vaginal intercourse during the cycle if adequate contraception is not used.
- Bruising from injections and withdrawal of blood.
- There may be certain long-term risks associated with the use of fertility drugs. These risks include ovarian cyst formation or rupture, ovarian over-stimulation, possible increased risk for ovarian cancer.

(8) I consent and agree that any child born to the recipient or recipient couple shall be deemed the natural child of recipient or recipient couple. I agree that I will undertake no action or proceeding to challenge the legitimacy of any child born to the recipient.

(9) To the best of my knowledge, I have no communicable disease, and do not now, nor have ever suffered any physical or mental impairment or disability, whether inherited or as a result of any disease or ailment.

(10) In connection with providing my services as a donor, I understand and agree:

- a) To undergo blood tests for infectious disease, drug screening and hormone levels.
- b) To undergo genetic testing for diseases that can be transmitted.
- c) To undergo a psychological screening with a psychologist to determine my suitability to be a donor.
- d) To take all medication as instructed, including injections of a drug called Lupron (usually self administered) and fertility drugs (Pergonal and HCG) to stimulate my ovaries to produce several eggs to be retrieved at the time of egg aspiration.

Consent to Donate Eggs– Page 3

- e) To undergo frequent laboratory tests and vaginal ultrasounds in order to be closely monitored.
- f) To keep all appointments for all laboratory, vaginal ultrasounds and other tests that are needed.
- g) To abstain from intercourse or to use a non-hormonal form of contraception if I do have intercourse, such as condoms or a diaphragm.
- h) To notify ARHC if I engage in intercourse with a new partner.
- i) To refrain from the use of all recreational drugs and all but occasional alcohol use during my cycle.
- j) To report any prescription or non-prescription drug use.
- k) To donate my retrieved oocytes (eggs) to a recipient, and I RELINQUISH ANY CLAIM TO OFFSPRING THAT MAY RESULT FROM THE USE OF MY DONATED EGGS FOR IN VITRO FERTILIZATION.
- l) I understand that the recipient couple is responsible for any costs and expenses associated with my selection, screening and treatment in connection with the egg donation and retrieval.
- m) I understand that I am required to have my own health insurance. In the event that I experience medical complications or require hospitalization, I will be solely liable for the payment of any such expense and neither the recipient couple nor ARHC shall have any liability. Further, I hereby indemnify and hold harmless the recipient couple and ARHC, its officers, directors, shareholders and employees from any such medical and hospital expense arising from any such complication.

(11) I certify that I am at least 21 years of age.

(12) I hereby consent to the donation of my eggs and the procedures described in this consent form. I understand that if I am married that my spouse must also sign this consent form.

Dated: _____
(Name of Donor)

Dated: _____
(Witness)

(13) I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risks attendant to the donation of eggs and I hereby signify my agreement to my spouse's participation in the procedure.

Date: _____
(Name of Spouse)

Date: _____
(Witness)

Consent to Donate Eggs– Page 4

I, _____, one of the members of the assisted
(Print Name)
reproductive medical staff of ARHC, by my signature, indicates the foregoing consent
was read, discussed and signed in my presence.

Signature

Date

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...Exceeding patient expectations...”



Section 5

ARHC Contact Information

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



EGG DONOR PROGRAM **CONTACT NAMES**

- 1. Cheryl Tropsic**
Donor Oocyte Coordinator
1-800-210-5653
- 2. Laura Ostrowski**
Practice Manager
1-800-210-5653
- 3. Billing Department**
1-800-836-6637
- 4. Vernita Walton Roldan**
IVF Coordinator
1-800-210-5653

EMERGENCY TELEPHONE CALLS

Please call the main number after business hours for all emergencies. Please leave a message with our answering service and they will contact a nurse or doctor who will return your call.

www.Chicago-IVF.com
1-866-IVF-CHGO

Our Mission Statement: “...Exceeding patient expectations...”



Section 6

Additional Educational Resources

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...*Exceeding patient expectations...*”



Resource List

Advanced Reproductive Health Centers, Ltd.
www.Chicago-IVF.com

HealthBanks – Extended Education Infertility Information Website
www.HealthBanks.com

IVF Care (Infertility Pharmacy)
www.IVFCare.com

Freedom Drug (Infertility Pharmacy)
www.FreedomDrug.com

American Society for Reproductive Medicine
www.ASRM.org

American College of Obstetricians and Gynecologists
www.ACOG.com

Resolve: The National Infertility Association
www.Resolve.org

Center for Disease Control (CDC)
www.CDC.gov

Organon Pharmaceutical Inc.
www.Organon-USA.com

Serono Pharmaceutical Inc.
www.Serono.com

www.Chicago-IVF.com
1-866-IVF-CHGO

Our Mission Statement: “...Exceeding patient expectations...”