

Thank you for your interest in our egg donor program. Our goal is to facilitate the meeting of prospective parents with egg donors. We arrange and organize all of the complexities that are associated with the donation cycle. With your help and ours, we are creating the possibility for a couple to have a child. You, of course, are the key to their success. Without your selflessness and open heart, this possibility would not exist. Please know that we will do our part to guide you and educate you on the process of egg donation from start to finish. Always know that we keep your health and safety our #1 concern. Once again, thank you for offering a gift of a lifetime!

The first step in the process is **completing** this application and **sending us recent photos of yourself (a close up of your face as well as a full body shot)**. Once we have received your **COMPLETE** application and photos and it has been approved, we will contact you for an appointment.

The process of matching can sometimes happen right away or can take months; it just depends on what our patients are searching for. After the match is made, the entire donation can take 2-3 months depending on where you and the intended mother are in your cycles. You will receive compensation for your donation in the amount of \$3,000 for first time donors; second time donors who have a proven track record may request a higher compensation depending on her qualifications. Please also keep in mind that you are responsible for reporting this income to the IRS.

Please note that it is your responsibility to keep us updated if your phone number or address changes.

Thank you again, and we look forward to getting to know you.

Sincerely,

Susan Nunn, BS

Susan Nunn, BS
Donor Egg Coordinator

Donor Registration

PATIENT REGISTRATION FORM				
PATIENT INFORMATION				
First:	M.I.:	Last:	How would you like to be addressed:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	SS#:	Religion:
Birth date:	Age:	Race:	Marital Status:	Spouse's Name:
Patient Employer:		Patient's Occupation:		
Address:		City:	State:	Zip:
Emergency Contact (not living with you):			Relationship to Emergency Contact:	
Emergency Contact Phone:		Home:	Work or Other:	
Is it okay to leave a detailed message for you at and/or with:				
Home?	Y or N	Work?	Y or N	Cell? Y or N
		Family/Spouse?	Y or N	
What is the best time and place to contact you?				

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

Date: _____

Donor Requirements

Donors must be between the age of 21 and 32, a **non-smoker** and have an exceptional health history. All donors must be within 40 lbs of their "ideal" weight to ensure the health of the donor and her egg quality. If you have had children in the past, this is helpful but not a requirement. This sometimes will reassure the prospective parents of your proven fertility. We only allow up to 6 donations total whether it be at our center or elsewhere. Please be honest regarding this specification.

The Donation Process

Depending on the circumstances you may be expected to sign a contract drawn up from the prospective parent's legal counsel. The Fertility Center of Colorado will help answer any questions you may have. Visits will entail a consultation, blood screening for communicable diseases and hormone levels, a urine drug analysis as well as a vaginal ultrasound; this takes place on day 2, 3 or 4 of your menstrual cycle so be sure to inform the clinic of the first day of your period. The first day is considered a full, bright red flow before 5:00 P.M; not spotting. You will need to be off any type of birth control for a month before testing your hormone levels. These tests consist of an estradiol and a follicle-stimulating hormone, which will help to determine egg quality.

Once hormone testing is done, you will be placed on a birth control pill along with the prospective mother to coordinate your cycle. You will remain on the pill for 2 to 3 weeks. Your first injection of Lupron will be overlapped with your pill for approximately 7 additional days. Once you have taken your last pill, you will remain on Lupron injections and expect a period to report to your clinic; these injections will last approximately 7-14 days. You will then have an additional blood test to check your suppression status; this is done with another estradiol level (blood draw).

After you have established suppression, you will typically cut your dose of Lupron in half and begin your stimulation agents to begin enhancing follicular growth. Most women will stimulate on average 10 days, some will be ready for egg retrieval sooner and some take additional time. The stimulation agents are a form of synthetic FSH or follicle-stimulating hormone to increase follicular growth on the ovaries. Some forms of FSH you may hear of are Gonal-F, Follistim, Menopur and Bravelle.

You can expect to make 4-6 monitoring visits to check the status of your follicular growth. This is done by vaginal ultrasound and blood draws. At the end of each monitoring visit, we will inform you of your dosage of medication; this may stay the same throughout the cycle or could be increased or decreased depending on your response. Once we feel you are at a stage deemed "ready" for egg retrieval, we will instruct you to take a shot of hCG (human Chorionic

Gonadotropin), which will give the follicles their final maturation. The injection of hCG is extremely time sensitive. You **MUST** take this injection at the exact time that it is instructed because your egg retrieval will be scheduled 36-38 hours later. If you fail to take this at the time instructed, this will cause you to ovulate prior to the retrieval and the entire cycle will be cancelled.

During the egg retrieval, you will be placed under "light" anesthesia. You will be breathing on your own, but you will be comfortably sleeping during the procedure. The egg retrieval or aspiration is done using a vaginal ultrasound with a needle guide. The entire procedure is monitored through ultrasound to ensure accuracy of placement. The physician will make a small puncture in each follicle on both ovaries until all of the follicles have been emptied. This is done using a small suction that is attached to the needle. You may be tender and bloated throughout your monitoring and after the egg retrieval. Making sure you stay well hydrated and rested will help decrease the water retention and bloating.

Once the procedure is complete, you will remain at the clinic for approximately 1 hour for recovery. This will vary depending on your individual retrieval. After the anesthesia has worn off, you will be discharged to your designated driver. You are not allowed to drive for 24 hours after anesthesia initiation and therefore must bring someone with you.

You can expect to return to normal work and activities a day or two after the retrieval. It is very important that you follow the post-op instructions. This will ensure that bloating is resolved in a timely manner. You should expect your period in approximately 2-4 weeks after the retrieval; this varies from each individual. **YOU ARE STONGLY ADVISED NOT TO HAVE SEXUAL INTERCOURSE UNTIL YOU HAVE HAD YOUR PERIOD!!**

Final compensation will be received within a week of the retrieval. Please remember you are responsible for reporting this income to the IRS, The Fertility Center of Colorado does not withhold for you and is not responsible for reporting this to the IRS.

During your entire donation, you will not be required to make any type of payments. Everything will be covered by the prospective parents. If you end up covering something, please keep all receipts for reimbursement.

Many donors will ask whether or not their donation was successful for the prospective parents. This will be individually based and each couple will decide if they are comfortable with you knowing the outcome of a pregnancy or not. Some donors do not want to know if the prospective mom achieved pregnancy or not, please make this clear ahead of time so we may respect your wishes as well.

Potential Risk Factors

As with any medication, there are potential side effects from both the Lupron and the stimulation agent. Two of the most common complaints of Lupron are headaches and insomnia (this drug has not been approved by the FDA for this protocol). You may take Tylenol **only** during this process. Ibuprofen is not allowed due to the anti-inflammatory response it creates. With each stimulation agent, you will experience bloating and tenderness in the pelvic region due to the enlargement of the ovaries. Some of the agents sting upon injection and could also leave slight swelling or bruising at the injection site. These will dissipate with time and are not

harmful. You can expect to gain a small amount of weight due to the bloating (2-7 lbs); this will also resolve itself in a couple of weeks after the egg retrieval.

The most common risk with ovarian stimulation is "hyperstimulation" of the ovaries. The goal is to "over" stimulate, not "hyperstimulate". If this occurs, you will possibly be required to repeat a visit back to the clinic to have the added fluid aspirated out of the ovaries. This is done similarly to the egg retrieval itself, although usually you are not given anesthesia for this process. It is a quick procedure that will help you rid of the excess fluid. If you are hyperstimulating during the monitoring process, the physician may be inclined to cancel the cycle due to health risks to yourself.

In severe cases, ovarian twisting could occur (less than 1%) in which the ovaries cut off their own blood supply. In this case, the ovary would have to be removed. There are also additional risks to surrounding organs such as nipping the bladder. Your risk factors should be discussed in detail with your physician before consenting to the procedure.

Do's and Don'ts During Your Donor Cycle

Do's

- Eat a healthy well balanced diet.
- Take a daily prenatal or multivitamin.
- Maintain your regular exercise habits and decrease once ovaries enlarge with stimulation; you may do lower impact at this time.
- Use only Tylenol or Sudafed~ NO IBUPROFEN!
- Report fevers to your clinic.

Don'ts

- Do not try any weight loss programs.
- Do not use any diet or herbal pills/remedies.
- Do not drink alcohol.
- Keep pulse below 140 beats per minute.
- No intercourse after period starts.

Egg donation is a fairly new procedure and long-term risks are still being established. The number one concern is how it will affect the donor's ability to conceive later in life. This procedure has not shown any increased risks for infertility, many donors have had healthy, successful pregnancies of their own after a cycle. Cancer is another risk factor that is also being studied and thus far has not shown any increased risk to donors.

Thank you again, and we look forward to sharing this amazing experience with you!

Donation Screening Form
(Incomplete applications will not be accepted)

Date: _____

Name: _____

Address: _____

Social Security #: _____ Home #: _____

Work #: _____ Cell #: _____

May we leave a message at: home work cell

Partner's Name (Last Name, First Name): _____

Relationship (circle): married single with relationship single without relationship

Who may we contact in case of an emergency: _____

Phone: _____

Are you currently listed with any other clinics or agencies? _____ If yes, whom?

Have you ever been denied entry into another egg donor program? _____ If yes, please explain
in detail: _____

If a match is not immediately available, how long are you willing to stay in TFCC's database?

0 – 3 months _____ 4 – 6 months _____ 7 – 9 months _____ indefinitely _____

PHYSICAL CHARACTERISTICS

Date of Birth: _____ Height: _____ Weight: _____

Eye Color: _____ Blood Type: _____

Measurements: Bust _____ Hips _____ Waist _____

Body Frame: _____ small _____ medium _____ large

Skin Color (circle): Fair Med Dark Olive Do you tan easily? _____ Burn? _____

Natural Hair Color: _____

Hair (check all that apply):

____ curly/wavy (naturally) _____ curly/wavy (processed)

____ straight (naturally) _____ straight (processed)

____ average texture _____ thin texture

____ premature graying (at what age _____)

Race (e.g. Caucasian, African American, Asian, Hispanic, etc.): _____

Ethnicity (e.g. Irish, German, French,....): _____

Mother's Side: _____

Father's Side: _____

Personal Characteristics

Birthplace: _____

Religion Born Into: _____ Religion Practiced: _____

Marital Status: ___ single ___ married ___ divorced/separated ___ widowed

Education: ___ Completed grade school ___ Completed high school

___ Currently in college, pursuing degree in _____

College attending: _____

___ Completed college, degree in _____

What degree did you receive (circle one): Associate BS MS PhD

___ Currently pursuing advanced degree in _____

___ Completed advanced degree in _____

Current occupation: _____

Vision (without corrective lenses): ___ Poor ___ Fair ___ Good ___ Excellent

Do you wear corrective lenses: ___ Yes ___ No

For what problem(s): ___ Nearsighted ___ Farsighted

___ Other (explain): _____

Hearing (without corrective aids): ___ Poor ___ Fair ___ Good ___ Excellent

Teeth: ___ Poor ___ Fair ___ Good ___ Excellent

Do you smoke cigarettes: ___ Yes ___ No If yes, how many cigarettes per day? _____

Do you consume alcohol: ___ Yes ___ No If yes, what quantity/how often: _____

Diet: ___ Vegetarian ___ Non-Vegetarian

Diet (nutrition): ___ Poor ___ Average ___ Good

Personal Health History

Allergies: Yes No

If yes, are they to: Foods Medication(s) Environment Other

For each allergy, describe specific substance and reaction(s) and age first noticed:

Substance: _____ Reaction(s): _____ Age: _____

Substance: _____ Reaction(s): _____ Age: _____

Substance: _____ Reaction(s): _____ Age: _____

Explain allergies you have outgrown: _____

Exercise: None Occasional Regular

Type of Exercise: _____

Have you had any surgery(ies)? If yes, please list: _____

Have you had any hospitalization(s) not mentioned above: _____

Have you had a blood transfusion? Yes No

Have you had major radiation or x-ray exposure? Yes No

If yes, explain: _____

Are you currently taking any medications, prescribed or over the counter? Yes No

If yes, please list: _____

PERSONAL HEALTH HISTORY (CONTINUED)

Are you currently using any recreational drugs? Yes No

If yes, please list: _____

Have you ever misused prescription medication(s)? Yes No

If yes, please describe in detail the types of prescription medications, quantities and frequency:

If yes, please state when the most recent misuse of any prescription medication(s) was, and what the specific agent was: _____

Have you ever participated in Mental Health Counseling? Yes No

If yes, please explain: _____

Fertility History (female):

Number of pregnancies: _____ Dates of pregnancies: _____

Number of miscarriages: _____ Dates of miscarriages: _____

Number of abortions: _____ Dates of abortions: _____

Number of stillbirths: _____ Dates of each stillbirth: _____

Number of children: _____

Age	Sex	Birth Date	Health/Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are your menstrual periods regular: Yes No

How long is your monthly cycle: _____ days (count start of flow to start of next flow)

How many days does your menstrual flow usually last: _____ days

PERSONAL HEALTH HISTORY (CONTINUED)

Have you ever been told you were infertile: Yes No

If yes, when: _____ On what basis: _____

Birth Control method used: _____

Is there any history of fertility problems in your family (difficulty conceiving or miscarriages):
 Yes No If yes, please explain: _____

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings? Yes No

If yes, please explain: _____

Sexual History:

Sexual preference: heterosexual bisexual homosexual

Please state the number of sexual partners you have had in the past 1 year: _____

Do you have a sexual partner now? Yes No

Is your relationship monogamous: Yes No Not sure

Have you ever had sexual relations with someone who was diagnosed as having or suspected that he/she had AIDS or was infected with HIV? Yes No

Have you or any of your sexual partners:

- had sex in exchange for money or drugs in the preceding 5 years? Yes No
- been confined to a correctional facility or been incarcerated for more than 72 consecutive hours during the previous 12 months? Yes No
- within the past 12 months undergone tattooing, acupuncture, ear or body piercing in which shared instruments are known to be used? Yes No
- received injections of human pituitary-derived growth hormone (pit-hGH)? Yes No

PERSONAL HEALTH HISTORY (CONTINUED)

Have you or any of your sexual partners had or been contact with anyone who has had:

	<u>Self</u>	<u>Partner</u>	<u>When</u>	<u>How Often</u>
HIV				
NSU (non specific urethritis)				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Viral Hepatitis B or C				
Hemophilia				
Received human-derived clotting factor concentrates				
IV (intravenous) drug use				
Other sexually transmitted diseases				

PERSONAL HEALTH HISTORY (CONTINUED)

Have you ever donated your eggs before? _____ If yes, please list dates and outcomes:

Mo/Year	# Eggs Retrieved	# Eggs Fertilized	Did a pregnancy occur?	Did a live birth occur?

Were there embryos left to cryopreserve (freeze)? _____ If yes, how many? _____

Have you been sexually active in the past 6 months? _____

Are you currently sexually active? _____ If yes, is it a monogamous relationship and for how long? _____

Have you or your partner ever had a sexually transmitted disease? _____ If yes, when and what was your treatment regimen? _____

Have you ever been diagnosed with any gynecological problems such as endometriosis, ovarian cysts, abnormal Pap smears, fibroids, polyps? _____ If yes, please explain treatment

Please mark any that apply to you within the last 12 months:

- Exposure to HIV
- Exposure to Hepatitis B or C
- Had sex in exchange for money or drugs
- Intravenous drug use
- Piercing or tattoos

Personal Work History

List jobs held in the past five years:

<u>Jobs/Duties</u>	<u>Year Began</u>	<u>Year End</u>

Have you been exposed to any toxic chemicals in your living or work environment?

_____ Yes _____ No If yes, please explain: _____

Family Health History

Describe biological family members according to the following characteristics:

(MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather)

(Use natural eye and hair color; fair/dark, etc. complexion; height, small frame, etc., body type; and vision with corrective lenses.)

	<u>Eye Color</u>	<u>Hair Color</u>	<u>Complexion</u>	<u>Height</u>	<u>Body Type</u>	<u>Vision</u>
Mother						
Father						
Brother(s)						
Sister(s)						
MGM						
MGF						
PGM						
PGF						

FAMILY HEALTH HISTORY (CONTINUED)

How many blood siblings are in your immediate family (including yourself)? _____

Number of Males: _____ Number of Females: _____

Are there any twins or triplets in your family? _____ Yes _____ No

If yes, what relation are they to you? _____

List below the ages of the following biological members of your family; if they are deceased, please list cause of death.

	<u>Age if living</u>	<u>Age at time of death</u>	<u>Cause of death</u>
Mother			
Father			
Brother(s)			
Sister(s)			
MGM			
MGF			
PGM			
PGF			

Are there any known diseases or conditions that run in your family? ____ Yes ____ No

If yes, please identify: _____

Have you ever been tested as a carrier of:

Tay-Sachs disease ____ carrier ____ non-carrier ____ unknown

Sickle Cell disease ____ carrier ____ non-carrier ____ unknown

Thalassemia ____ carrier ____ non-carrier ____ unknown

Cystic Fibrosis ____ carrier ____ non-carrier ____ unknown

Have you or any family members listed above had genetic counseling? ____ Yes ____ No

If yes, please describe: _____

FAMILY HEALTH HISTORY (CONTINUED)

Carefully review the following list of medical problems and identify any which are present in biological family members:

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
HEART							
Stroke							
Heart attack							
Heart disease or defect							
1. From birth							
2. Other							
Hardening of the arteries							
High blood pressure							
High cholesterol							
BLOOD							
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding disorder							
HIV/AIDS							
Leukemia							
Other blood disorder							
RESPIRATORY							
Asthma							
Emphysema							
Tuberculosis							
Cystic Fibrosis							

FAMILY HEALTH HISTORY (CONTINUED)

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
GASTRO-INTESTINAL							
Ulcer of stomach or duodenum							
Hepatitis (all types)							
Cirrhosis							
Other liver disease							
Ulcerative colitis							
Crohn's disease							
Pyloric stenosis							
Rectal disorder							
METABOLIC/ ENDOCRINE							
Diabetes (age of onset)							
Thyroid disease							
Goiter							
Hyperactivity							
Phenyl Ketonuria (PKU)							
Dwarfism							
URINARY							
Kidney disease							
Other disease defect of urinary tract (urethra, bladder, ureter)							
GENITAL/ REPRODUCTIVE							
Hermaphroditism/ Ambiguous Genitals							
Hypospadias							
Uterine fibroids							
Ovarian cysts							
Endometrioses							

FAMILY HEALTH HISTORY (CONTINUED)

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
REPRODUCTIVE OUTCOMES							
2 or more miscarriages							
Stillborn							
Death of a newborn infant							
Infertility							
NEUROLOGICAL							
Migraines							
Mental retardation							
Senility before age 50							
Multiple Sclerosis							
Cerebral Palsy							
Epilepsy/seizure							
Hydrocephalus							
Spina bifida / neural tube defect							
Parkinsonism							
Creutzfeldt-Jakob Disease							
Other diseases							
MENTAL HEALTH							
Depression							
Schizophrenia							
Manic depressive or bipolar disorder							
Huntington's disease							
Other mental health disorder requiring hospitalization (i.e., suicides, nervous breakdowns, etc.)							

FAMILY HEALTH HISTORY (CONTINUED)

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
MUSCLE/BONE/ JOINTS							
Scoliosis							
Muscular Dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus or other auto immune diseases							
Osteoporosis							
Marfan Syndrome							
Arthritis							
SIGHT/SOUND/ SMELL							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Retinitis Pigmentosa							
Any other sight/sound/smell disorder							
SKIN							
Acne							
Eczema							
Pigmentation disorders							
Neurofibromatosis							
Other disorders of the skin							

FAMILY HEALTH HISTORY (CONTINUED)

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
CONGENITAL ABNORMALITIES							
Cleft lip/palate							
Congenital hip problems							
Club feet							
Other							
CHROMOSOMAL ABNORMALITIES							
Down Syndrome							
Other (i.e. Turner, Fragile X, etc.)							
CANCER							
Breast							
Ovarian							
Colon							
Skin							
Thyroid							
Cervical							
Uterine							
Other							
OTHER							
Alcoholism							
Drug abuse, misuse or addiction							



PERSONAL AND MOTIVATIONAL

Reason for wanting to donate eggs: _____

In your own words, describe your personality and character: _____

What are your hobbies, interests, and talents: _____

What do you think is your best physical quality? _____

What do you like most about yourself? _____



Personal and Motivational (continued)

What do you like least about yourself? _____

What is your best intellectual quality? _____

Do you have any particular athletic abilities? _____

What are your goals in life, personal and professional? _____

Once you are chosen as an egg donor, first morning appointments are mandatory. You are not able to choose the dates of your appointments, as they will coincide with the clinic's requirements and timing of your cycle. You will be required to attend 7-10 monitoring appointments prior to the actual egg retrieval. Morning appointments can be arranged as early as 8:30 -9:00 a.m. If your schedule cannot accommodate this criterion, you will not qualify for the egg donation process.

I hereby certify that I have answered all the above questions honestly, and to the best of my knowledge and ability. I recognize that TFCC representatives, the reviewing health care team, and potential recipients, shall rely on this information in judging my suitability as a donor candidate.

I also have been informed that this form will be kept by TFCC and may be provided (with identifying information such as name, address, and social security number, removed) to potential recipients and/or to children ultimately born as a result of the donation cycle. I hereby consent to the delivery of such non-identifying information.

I also promise that, should I receive additional information, in the future years, which indicates that I suffer from an inherited disease or condition, I shall inform TFCC.

Signature

Date