CONSENT FOR EGG DONATION (ANONYMOUS DONOR)

1. I, _____, consent for the physicians and staff of the Women &
(print Donor's full name)
Infants Fertility Center (WIFC) to perform oocyte (egg) retrieval on me for the purpose of donating the retrieved eggs ("donor eggs") to another patient for use during in vitro fertilization (IVF) procedures.

2. Screening

I understand that WIFC follows a screening process prior to the transfer of reproductive tissue from one patient to another. I am required to complete a profile detailing my personal, medical and family history to the best of my ability. I will undergo an evaluation, including blood tests, to screen me and my partner (if applicable) for HIV and other infectious diseases, a psychological consultation, and a history and physical examination, and any other tests the WIFC physicians deem appropriate.

3. Medications (hyperstimulation), monitoring and blood tests.

The use of "fertility drugs," such as oral contraceptive pills, GnRH-agonists, gonadotropins, GnRH-antagonists, human chorionic gonadotropin (hCG), progesterone, estradiol, letrozole, and antibiotics, has been explained to me, and their respective risks and side effects have been discussed. I understand that some of these drugs may be used "off label" (not approved by the FDA for this use). I am aware that some of these medications are administered by intramuscular or subcutaneous injection and may cause bruising and discomfort at the injection site.

I understand that complications may arise as a result of taking fertility drugs. Complications from taking these medications include, but are not limited to:

- infection
- ovarian enlargement and/or hyperstimulation*
- damage to the ovaries
- adverse or allergic drug reaction
- very rarely, blood clots, stroke, heart attack, and/or death

My physician has discussed with me and I understand that Ovarian Hyperstimulation Syndrome (OHSS) can be a serious risk/complication from taking fertility drugs. Symptoms of OHSS include increased ovarian size, ovarian torsion (twisting of the ovary), nausea and vomiting, accumulation of fluid in the abdomen, breathing difficulties, an increased concentration of red blood cells, kidney and liver problems, and in the most severe cases, blood clots, kidney failure, or death. In severe form of OHSS, serious complications may require hospitalization and medical intervention.

I acknowledge the importance of maintaining close contact with the physicians and staff at WIFC ("IVF team") during the period of time while I receive these medications and for a minimum of two (2) weeks afterwards. While taking any of the above medications, I will be closely monitored by the IVF team with blood tests. This monitoring may be daily and carries the risk of mild discomfort and bruising at

the venipuncture (blood draw) site.

I am aware that transvaginal ultrasound examinations are performed, and that there may be some discomfort with this procedure. If monitoring suggests a low probability for successful egg retrieval, my stimulation cycle may be stopped and no egg retrieval is performed. Alternatively, if my physician thinks that I am at risk for severe OHSS, the stimulation medications may be discontinued and no egg retrieval is performed.

4. Transvaginal Oocyte (Egg) Retrieval

Oocyte (egg) retrieval is the removal of eggs from the ovaries through use of a transvaginal ultrasound probe and a needle. At a time determined by the IVF team, I will be admitted to Women & Infants Fertility Center as an ambulatory patient. If anesthesia is required for egg retrieval, I will sign a separate anesthesia consent form on the day of procedure. Rarely, the ovaries are not accessible by the transvaginal route, and transabdominal retrieval is necessary.

Risks of egg retrieval include, but are not limited to:

- Infection: Bacteria normally present in the vagina may be inadvertently transferred into the abdominal cavity by the needle and may cause an infection of the uterus, fallopian tubes, ovaries or other intra-abdominal organs. Treatment of infection could require the use of oral or intravenous antibiotics. Severe infections occasionally require surgery to remove infected tissue. Infections can have a negative impact on fertility.

- Bleeding: Small amounts of blood loss are common during egg retrievals. Major bleeding may require surgical repair. The need for blood transfusion is rare; however, in very rare circumstances, unrecognized bleeding can lead to death.

- Trauma: Despite the use of ultrasound guidance, it is possible for organs or structures within the abdomen to be injured. Injury to internal organs or structures may result in the need for additional treatment, including but not limited to admission to the hospital, blood transfusion or surgery.

The exact number of eggs retrieved is not determined until their final microscopic evaluation. I understand that there is no guarantee that any eggs will be retrieved during this process.

Following egg retrieval, I may experience mild abdominal discomfort and/or light vaginal bleeding. I understand that if I experience severe abdominal pain, heavy bleeding, and/or a temperature of over 100.5 degrees F, I need to contact WIFC immediately. If I am experiencing a true medical emergency, I understand I should call 9-1-1 or go directly to the closest emergency department.

5. Donation

I understand, intend and agree that following egg retrieval, all of the eggs retrieved are donated to another patient for use in the performance of IVF. I understand that upon such donation, I am unconditionally and irrevocably relinquishing, releasing and giving up forever any and all rights or claims to the donor eggs.

I am aware that, except as required by law, WIFC keeps my identity confidential, and will not disclose my identity to the recipient and partner (if applicable) of the donor eggs.

I acknowledge that the recipient of the donated eggs may have the right to donate to another person any frozen embryos (eggs fertilized by sperm) created from use of the donor eggs. I shall make no attempt to discover or to disclose to any other person whether such donor eggs have been used in IVF procedures or the outcome of such procedures.

I shall make no attempt to identify, find, locate or knowingly contact the recipients of: 1) the donor eggs, 2) any embryos created with the donor eggs, and/or 3) any child(ren) resulting from any IVF procedures utilizing the donor eggs.

I acknowledge that WIFC may dispose of any donor eggs that are not used by the recipient.

6. Future Genetic Screening

I understand that any present or future child(ren) born to me may be related (genetically, biologically or both) to a child created from use of the donor eggs, and that my child(ren) should have blood tests, and other appropriate genetic screening tests to determine a potential genetic relationship with a partner prior to entering into any relationship that could produce a child. I understand that my child(ren) should disclose to any partner the potential for genetic relationship and the importance of the partner undergoing blood tests and other appropriate genetic screening tests as well.

I acknowledge that WIFC has no obligation or duty whatsoever to make any of these disclosures to any person at any time.

7. Discarded Material

In the hope that I may help others, I donate for teaching or research purposes any unused biological material which otherwise would be routinely discarded. I understand that no pregnancies will be generated using this material. I understand that by agreeing to this donation there is no additional risk to me. I also understand that I may refuse to donate this material and the treatment given will not be affected.

My limitations are: _____

8. General Consent Provisions

I understand that the lists of risks and complications related to the above procedures are not complete and that my physician has discussed with me that other unforeseen risks do exist and that additional procedures may be required. I consent to those procedures which my physician deems necessary.

Alternative options to egg donation and the risks and benefits of these alternative options have been explained to me by the IVF team, including procedures that are not performed here, and other non-medical options such as non-treatment, and I understand them.

I understand that I may require a blood transfusion as a result of the above procedures. I understand that blood transfusions are routinely done with blood donated by volunteer blood donors and that if time and my condition permits, I will be given the option to have family members donate for me. I understand there are unforeseen complications associated with a transfusion, including but not limited to transfusion transmitted diseases (HIV, AIDS), allergic reactions, chills, fever, heart, lung or kidney problems or even death. The associated risks and benefits of a blood transfusion have been discussed with me. I acknowledge that blood transfusion treatment alternatives have been discussed with me.

I acknowledge that the physicians at the Women & Infants Fertility Center are only managing infertility and that I am responsible for obtaining my general medical and gynecologic care through other physicians.

I understand that Women & Infants Hospital is a teaching hospital where fellows, residents and advanced practicing medical and nursing students may observe and/or perform IVF and its related procedures under the direct supervision of licensed practitioners of accredited teaching programs.

I consent to the taking of photographs, videotapes and/or illustrations of procedures, eggs, sperm, embryos, etc. and other medical problems for diagnostic, educational or scientific purposes, provided my identity is not revealed.

I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantee or promise has been given to me by anyone as to the results of my treatment. I understand that the above described procedures are done by the Women & Infants Fertility Center team and that my primary physician may not be the one doing this.

I understand that WIFC makes no representation, express or implied, with respect to the nature of the legal relationship of any embryos (eggs fertilized with sperm) created or any child(ren) born as a result of the use of donor eggs. I understand that I should consult with legal counsel in this regard.

I acknowledge that this form has been explained to me and I understand its contents. I have had the opportunity to ask questions which have been answered to my satisfaction.

Time: _____ A.M./P.M. Date: _____ Signature: _____
Donor

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by this donor.

Time: _____ A.M./P.M. Date: _____ Signature: _____
(Provider)

Print Name:_____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this donor.

Time: _____ A.M./P.M. Date: _____ Signature: _____
(Interpreter)

Print Name:_____
(Interpreter)