**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

Dear Potential Donor,

For many couples, a medically appropriate treatment option, egg donation, is the only way they will ever experience the joys of parenthood. Egg Donation represents a real chance for conception when the woman, for a wide variety of reasons, is unable to produce her own healthy eggs.

The process of egg donation is complex but you can rest assure our experienced physican and staff will guide you and the recipient through each step of the process, maintaining the highest standards of quality control. We believe egg donors are special people who act selflessly not to save a life, but to create it.

Egg donation involves the removal of eggs from the ovaries of a donor who has undergone ovarian stimulation with the use of fertility drugs. The eggs are then placed together with the recipient's partner's sperm, allowing for In Vitro Fertilization. The resulting fertilized eggs (embryos) are then transferred to the recipient's uterus following hormonal preparation.

Egg donation begins with an introductory interview with our physician and at that time you will receive a comprehensive medical history questionnaire and personal profile form to complete. These forms allow us to officially qualify you for our egg donor program and enable us to begin the process of matching you with a suitable recipient couple. Once this is completed and you are accepted into our egg donor program, you will be scheduled for a variety of medical tests (involving blood work and ultrasounds). These tests must be performed at specific points throughout your menstrual cycle and for that reason, may require more than one visit.

Once the egg donation begins, you will be given medications for up to 12-15 days to stimulate multiple egg production in your ovaries. At the same time, the recipient's uterus is being prepared through medications to receive the resulting embryos. Then, at a time which is determined by your physician, you will be given IV sedation and your eggs will be retrieved via transvaginal ultrasound. The egg retrieval will be performed here in the office. After the eggs are retrieved your portion of the egg donation is complete.

It is important to note that during the ovarian stimulation phase, it will be necessary to be seen every one to two days in order to check your hormone levels and perform ultrasounds to monitor the number and size of your egg follicles. This is not only for your safety, but to provide essential information that will help us maximize the success of the cycle.

If you have any questions, regarding this process, please feel free to contact the office and the nurse will help clarify any problems you might have. We hope, that with your help, an infertile couple's dreams will soon come true and the sense of fulfillment you'll receive will be priceless.

Sincerely,
Prakash Thiruppathi, M.D.

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

*General Requirements
*Must be between the ages of 18 and 35
*Must be in excellent general health
*Height and Weight proportionate
*Not be on Depo-Provera birth control
*Not use casual drugs (you will be tested)
*Not have any type of Sexually Transmitted Diseases
*Must be able to attend frequent doctor visits during cycle
*Must be willing to undergo psychological testing

This is a list of the tests routinely done on donors in our program. Additional testing for certain diseases specific to a donor's ethnic background may be performed as well.

Blood Tests:
- Hormones: Estradiol, Luteinizing Hormone, Follicle Stimulation Hormone
- Blood Type & RH Factor
- Blood Chemistry
- Complete Blood Count
- Syphilis
- Hepatitis B & C
- HIV 1, HIV 11, & HTLV, 1
- Genetic Testing
- Cystic Fibrosis

**Cultures:**
- Chlamydia
- Gonorrhea
- Pap Smear

**Urine Drug Screen**
**Physical Exam**
**Ultrasound**
**Psychological Evaluation**

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

## Psychological Consent

The Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. requires all egg donors have an in person meeting with our Psychologist as part of the Donor Egg protocol.

A Psychologist serves several purposes in the third party reproduction process. Psychological testing and an in person clinical interview of the donor is done. The counselor then meets the donor and tries to assess if they are appropriate candidates for egg donation. The Columbus Center for Reproductive Endocrinology & Infertility follows the American Society for Reproductive Medicine guidelines for third party reproduction.

The purpose of this evaluation is to ascertain the mental and psychological nature of the potential donor. The donor's mental status on donating her genetic makeup is important. The reasons for donating will be explored.

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

## Directions for Applications Submissions

Please complete your application carefully and neatly. Enclose 2 recent color photos of yourself (up close and full body). Make sure the picture is clear and accents your facial features. The recipient families will see this photo. Also, if possible we ask that you include a third picture of yourself as a child.

Enclose a copy of your driver's license. Please make sure that the copy is legible. This copy will become part of your confidential folder that is kept in our office. This information will **NEVER** be released to the public. It is used for identity purposes only.

Sign the "Personal Information/Photo Release" Form.

Mail completed application with enclosures to the address above.

At this time we are experiencing a high demand for egg donors. Please send your application in promptly to allow us to get you matched with a suitable recipient.

## Directions for Photo Requirements

We require that you send legible photos.

Do not Xerox your photos.

Make sure you are the only one in the photo.

Do not send ***Glamour Shot***s photos. Recipients want to see the natural you.

Pictures must be at least 3x5 but no larger than 5x7

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

## Legal Notice

### Personal Information/Photo Release

(This is to be reviewed, signed and returned to with application)

I, as an egg donor applicant, acknowledge, understand, and agree by the act of submitting this application to have non-identifying information about myself (name, address, social security number, etc) kept confidential and will not be posted on the Center for Reproductive Endocrinology & Infertility's (C.C.R.E.I.) website. I understand that C.C.R.E.I. uses photographs to facilitate the matching process between egg donors and recipients. I understand that the term "photograph" as used herein emcompasses both still photographs and motion picture footage. I further consent to the reproduction and/or authorization for C.C.R.E.I. to reproduce and use said photographs for this purpose.

This information may include a picture(s) and other information that may be of an identifying nature. Confidential information is not given out under any circumstance.

The egg donor applicant acknowledges, understands and agrees to provide accurate and complete profile information as requested on the application form. In addition, the applicant agrees to provide accurate social, medical, biological, and historical information as request by C.C.R.E.I.

C.C.R.E.I. relies upon the accuracy of information provided by the applicant, and makes no representation or warranty, expressed or implied, as to the accuracy of the authenticity of information provided to the applicant, or furnished on behalf of this applicant. Verification of accuracy and authenticity of this information is solely with the applicant.

C.C.R.E.I. does not guarantee to promise that the applicant will be matched with a family who is seeking an egg donor, or promises any time frame in which the selection will be made. The applicant understands and acknowledges that there is a risk that they may never be matched with a family.

The applicant agrees to hold C.C.R.E.I. harmless and free from any liability as a result of any violation of any such law or regulation. The applicant hereby releases C.C.R.E.I. and any of its associations of affiliated companies, their directors, officers, agents, employees, customers and appointed advertising agencies from all claims of every kind of account of such use.

The applicant understands, acknowledges and agrees that C.C.R.E.I. has the right to remove the profile of any applicant who attempts, either intentionally or unintentionally to

provide false information, mislead, abuse or exploit the data base services of C.C.R.E.I. in any improper, illegal or immoral fashion.

I affirm that this release was not obtained through duress or other undue influence.

_____ _____

Printed Name of Applicant Time & Date

_____

Signature of Applicant

_____ _____

Signature of Witness Time & Date

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

# Application for Egg Donors

## Personal Information:

First Name: _____ Last Name: _____ MI:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone Number: _____ Work Phone Number:_____

Cell Phone Number: _____ Alternate Phone Number: _____

E-mail address: _____ Date of Birth: _____

May we contact you at work: Yes: _____ No: _____

If no, what is the best way we may reach you & what number: _____

What is your current employment position: _____

Social Security Number: _____ Driver's License Number: _____

Marital Status: Single_____ Married _____ Divorced _____ Separated _____

If married/separated, Spouse's Name: _____

Have you ever been pregnant before? Yes ____ No ____; How many times:_____

Do you currently have any children? Yes_____ No_____; How many?_____

What are their ages? _____ What is the sex of the child(ren)_____

## Physical Characteristics:

Age: _____ Height:_____ Weight:_____ Race:_____

Maternal Race: _____ Paternal Race: _____

Ethnic Origin: Italian: _____ Indian:_____ Native American_____ Irish_____ Dutch_____

Swedish:_____ French:_____ German:_____ Asian: _____Japanese: _____

Chinese: _____ Other: _____

Physical Build: Small_____ Medium_____ Large_____ Athletic_____

Natural Hair Color:_____ Natural Eye Color:_____

Do you wear: Glasses_____Contacts_____ What is your blood type_____

Natural Texture of your hair? Fine: ____ Thin____ Thick____ Curly____ Straight_____

How is your complexion? Fair____ Medium____ Olive____ Dark____ Freckles_____

Do you have dimples? Yes_____ No_____

What is your religion preferences?_____ Are you currently practicing?_____

Do you smoke? Yes_____ No_____ Have quit _____

If yes, how many per day? _____ For how long? _____

Please list all current prescription/non-prescription medications you are taking_____
_____

_____

Please explain what they are used to treat:_____

_____

_____

Were you adopted? Yes_____ No_____

If yes, do you have any knowledge of your medical history? Yes_____ No_____

Do you have any athletic abilities? Yes_____ No _____, If yes, what abilities:_____

_____

## **Educational Background**:

Highest grade completed: _____ Did you receive a diploma? Yes____ No_____

Year you graduated from high school:_____ GPA: _____

Vocational/Trade school attended:_____ GPA:_____

Year you graduated from college: _____ GPA:_____

SAT/ACT scores:_____ IQ score (if taken)_____

College major: _____ college minor:_____

Do you have any plans to further your education? Yes_____ No_____

If so, when and how? _____

_____

## Personal Characteristics

What is your reason for donating your eggs? _____

_____

_____

_____

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

_____

_____

_____

What do you like most about yourself? _____

_____

_____

What are your hobbies and interests? _____

_____

What are your goals in life? _____

_____

_____

Who do people tell you that you like? _____

What do you hope to gain out of being an egg donor? _____

_____

_____

This space is provided for you to tell us what makes YOU special. We want you to share something with the families that are looking at you for their potential donor.

_____

_____

_____

_____

_____

_____

## Egg Donation Experience

Have you donated previously? Yes _____ No_____

If so, how many times? _____ When:_____ Where:_____

How man eggs were retrieved? _____

Are you currently listed with other egg donation programs? Yes_____ No _____

Have you ever been listed with other agencies in the past? Yes _____ No _____

How were you referred to our program? _____

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

# Female Patient Questionaire

## Identifying Information

Date: _____

Name: _____ Date of Birth: _____
Partner's Name: _____ Date of Birth: _____
Address:_____
City : _____ State: _____ Zip:_____
Telephone (Day): _____Telephone(night) _____
Race:_____ Occupation: _____
Insurance Company: _____ ID#_____

## Habits

Do you follow a particular food diet or have any special dietary habits? If yet specify:
_____

List the forms & frequency of regular vigorous exercise (i.e. swimming, cycling, running) and the age you began:_____
_____

Do you use or have you ever used (check all that apply):
Alcohol_____ Wine_____ Beer_____ Cocktails_____
Number of glasses per week _____
Cigarettes _____ Number of packs per day _____
Do you now or have you ever used illicit or recreational drugs (marijuana, cocaine, etc)? Yes _____ No_____ If yes, please specify: _____

Caffeine _____ Number of cups per day_____

## Medical History

Weight _____ Height_____ Blood type(if known)_____
Have you lost greater than 20 pounds in the last year? _____
Have you gained greater than 20 pounds in the last year? _____
Have you ever had pelvic surgery? If yes, please specify_____
_____

Have you ever received x-rays to the pelvic area for therapy or diagnosis? If yes, specify: _____

Have you ever been treated for cancer? If yes, explain therapy: _____

_____

Do you have or have you ever had (check all that apply):

_____ Anemia _____ Colitis _____ Appendicitis

_____ Color Blindness _____ Arthritis _____Cystitis

_____ Allergies _____ Congential Disease _____ Blood Transfusion

_____ Diabetes _____ Nipple Discharge _____Dizziness

_____Breast Soreness _____ Endometriosis _____ Breast Lump

_____ Epilepsy

Do you take or ever you ever taken any of these types of medications (check all that apply):

_____ Diuretics _____ Tranquilizers _____ Antibiotics

_____ Decongestants _____ Hormones _____ Oral Contraceptives

_____ Antihypertensives

Are you currently taking any over the counter medications on a regular basis? Please specify: _____

**Endocrine History**

Have you noticed any of the following symptoms?

Increased Hair Growth _____ Face _____Body Since_____

Breast Secretion _____Yes _____No _____Clear _____ Milky Since_____

Skin Stretch Marks _____ Yes _____ No Location_____

Weight Gain _____Yes _____No Amount_____ Since_____

Weight Loss _____Yes _____No Amount_____ Since_____

Headaches _____Yes _____No Location_____ Since_____ Mild _____ Moderate_____

Problems with eyes _____Yes _____No Since _____

Nervousness _____Yes _____ No Since_____

Hair Loss _____Yes _____ No Location_____
Since_____

Dry Skin _____Yes _____No Since_____

Oily Skin _____ Yes _____No Since_____

Acne _____ Yes _____ No Locatation_____
Since_____

Increase in size of feet _____ Yes _____ No Since_____

Increase in size of hands _____ Yes _____ No Since _____

If you answered "yes" to any of the above questions, please explain:_____
_____
_____

**Developmental History**

Normal size at birth _____ Yes _____ No

Were you normal height and weight for your age? ____Yes _____ No

Age first noted breast development: _____

Age first noted pubic hair: _____

Age first noted axillary hair: _____

**Menstrual & Pregnancy History**
Age at first menstrual period: _____ Last period:_____

Are your periods regular? _____ Yes _____ No
If regular, what is the usual number of days between periods? _____
If no, how many times a year do you menstruate? _____

What is the usual duration of your period? _____

Do you have cramps before, during or after your period? _____
Are cramps: _____ Mild _____ Moderate _____ Severe

Do you have to take pain medications for cramps? _____ Yes _____ No
If yes, please specify medications: _____

Do you bleed or spot between periods? _____ Yes _____ No

Amount of flow during your normal period: ____ Mild ____ Moderate ____ Severe

Do you have ovulation pains? _____ Yes _____ No

Can you tell when your period is approaching? _____ Yes _____ No

How far in advance? _____ What are the symptoms?_____

How many pregnancies (including abortions) have you had? _____

Were they normal pregnancies? _____ Yes _____ No

List any problems with pregnancies:_____
_____

**Contraceptive & Sexual History**

What form of contraception do you use now or have you used in the past? Check all that apply:
_____ Pills _____ IUD _____ Diaphram _____ Withdrawl

_____ Condom _____ Rhythm _____ Foam/Jellies _____ None

For each contraceptive method used, specify length of use and reason for discontinuation:

| Method | Length of use | Reason for Discontinuation |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If you've ever been on oral contraceptives (pills) were your periods normal after stopping them:
_____ Yes _____ No

How many times a week do you and your partner have sexual intercourse? _____

Is intercourse painful or difficult for you? _____ Yes _____ No

Do you use lubricants for intercourse? _____ Yes _____ No
If yes, please specify which one: _____
Do you douche before or after intercourse? _____ Yes _____ No

Premarital Sexual Experience: _____

**Medical History**

Do you have or have you ever had in the past any of the following medical conditions:

| | | |
|---|---|---|
| _____Chlamydia | _____Chronic Bronchitis | _____ Chronic Headaches |
| _____Herpes | _____ Gallbladder Problems | _____ Gonorrhea |
| _____Heart Disease | _____Hepatitis | _____ High Blood Pressure |
| _____ Operations | _____ Hirsutism | _____ Psychiatric Disorders |
| _____ Injuries | _____ Rheumatic Fever | _____ Scarlet Fever |
| _____ Seizures | _____ Inguinal Hernia | _____ Thyroid Problems |
| _____ Kidney Infections | _____ Kidney Disease | _____Tubal Infections |
| _____ Liver Problems | _____ Tuberculosis | _____ Loss of balance |
| _____ Ulcers | _____ Vaginitis | _____ Visual Changes |
| _____ Mumps | _____ Measles | ____ Neurological Problems |
| _____ Pneumonia | _____ Phlebitis | _____ Ovarian Cysts |
| _____ Pelvic Infections | _____ Parasitic Infections | _____Poor sense of smell |
| _____ Immunizations for German Measles | | _____ Cancer |
| _____ Diabetes | _____ Exposure to chemicals and/or radiation | |

If you answered “yes” to any of the above, please specify in detail: _____
_____
_____
_____

Please list all tests performed, dates, results, and name of doctors in the past year:
_____
_____
_____

**Family History**

Have there been any of the following diseases in your family?

_____ Diabetes _____ Heart Disease _____ Spina Bifida

_____ Early Deaths _____ Hypertension _____Abnormal Genitalia

_____ Kidney Disease _____Tuberculosis _____ Muscular Dystrophy

_____ Limp Deformities _____ Cleft lip/palate _____ Recurrent Miscarriage

_____ Cancer _____ Birth Defects _____ Mongolism

_____ Blindness _____ Deafness _____ Menstrual Problems

_____ Cystic Fibrosis _____ Infertility _____ Mental Retardation

_____Depression _____ Sickle Cell _____ Congential Anomalies

If you answered "yes" to any of the above, please explain in detail: _____
_____
_____
_____

**Fertility History**

Have you ever been treated for infertility before? _____ Yes _____ No
If yes, who was your physician? _____

What was the cause of your infertility?_____

What drugs have you taken for infertility? (Check all that apply)

_____Clomid _____hMG (Pergonal) _____ Estrogen

_____ Progesterone _____Prednisone _____Antibiotics

_____Gonal-F _____ Follistim _____ Menopur

_____Repronex _____ Bravelle

Which of the following test have been performed?

_____Postcoital Test _____Ultrasounds _____Basil Body Temperture

_____ Antibodies _____Thyroid tests _____ Hormone Tests
(FSH, LH, Estrogen, progesterone, etc)

_____ Endometrial biopsy _____ Hystersalpingogram _____Hysteroscopy

_____ Laparoscopy _____ Chlamydia Cultures _____ Other

If you answered “yes” to any of the above test, were any of these tests abnormal?
_____

Have you ever had surgery for a tubal reversal? _____ Yes _____ No
If yes, please specify date:_____

Have you ever had surgery for pelvic adhesions or endometriosis? _____ Yes ___No
If yes, please specify date(s):_____

Have you ever had any surgeries on your cervix? _____ Yes _____ No

Have you ever had any other type of surgery (D&C, ovarian, appendectomy, thyroid)?
_____ Yes _____ No

Have you ever undergone artificial insemination or in vitro fertilization? __ Yes __ No
If yes, please specify dates:_____
Did you use your partner or sperm donor?_____

Is your partner seeing a doctor for evaluation of infertility? _____ Yes _____ No
If yes, please specify physician’s name: _____
Does the doctor feel that your partner has a infertility problem? _____ Yes _____ No
If yes, what is the diagnosis and how is he being treated?_____
_____

Has he ever fathered a child with another woman? _____ Yes _____ No
If yes, please specify date(s): _____

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILIY, L.L.C.**
2323 Whittlesey Road
Columbus, GA 31909
(706) 653-6344

**PRAKASH J. THIRUPPATHI, M.D.**

# Patient Responsibilities
# Donor Egg IVF Program

The C.C.R.E.I. team works very hard to assure that you receive highly individualized care that will optimize your chance of achieving a successful pregnancy. We ask for your assistance in making this process as efficient and as simple as possible by doing the following things:

1. **Be Proactive**: Please help us make sure that you are completing the necessary screening test in a timely manner. If is necessary to complete everything on your screening check list prior to being your Donor Egg IVF cycle.

2. **Nurse Coordinator**: For any questions regarding your donor egg cycle, test results or other medical questions, please call the nurse on her direct extension.

3. **Financial Questions**: Questions regarding your bill or insurance should be directed to the office manager. The Nurse or Doctor will not answer questions about your bills or insurance coverage.

4. **Answering Machine**: Please make sure that you have an answering machine, that identifies yourself by name or phone number, so that we can leave you messages regarding your medication doses. This is particularly important since this information becomes available at different times of the day, which makes coordinating schedules difficult. We are unable to call multiple phone numbers due to time restrictions.

5. **Medications**: Be sure to purchase all medications well in advance. Your order will be placed with a pharmacy that specializes in fertility medications. Please keep in mind that some of the medications are often difficult to find locally on short notice. You need to monitor your medications and inform the nurse at least two days prior to running out of a particular medication.

**COLUMBUS CENTER FOR REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY, L.L.C.**

2323 Whittlesey Road
Columbus, GA 31909

Prakash Thiruppathi, M.D.

# CONSENT FOR OOCYTE DONATION

Donor's Name: _____ DOB: _____

Spouse's Name: _____ DOB: _____

I/We understand that we are entering an agreement with the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. (C.C.R.E.I.) for the sole purpose of becoming an oocyte donor. We understand that either of us has the right to withdraw at any time to further participation in the In Vitro Fertilization Program and it will not adversely affect our relationship with C.C.R.E.I., the physician and/or staff caring for us.

We understand that we are entering this program in hopes of creating a child for prospective parent(s) who have undergone conventional therapy and has failed or the treatment was unacceptable. If medical and/or surgerical therapy has been tried, then there were adequate periods of follow-up for pregnancy to occur after thorough evaluation of female and male factors.

We warrant that all written representation and information provided to C.C.R.E.I., the In Vitro Program, Prakash Thiruppathi, M.D. nurse, embryologist or the prospective parent(s) are true, correct and complete. We understand that if any information given to C.C.R.E.I., the In Vitro Program, Prakash Thiruppathi, M.D., the nurse, embryologist, or the prospective parent(s) is false, unbeknownst to us, we may be disqualified from the In Vitro Program.

## Requirement for Participation

We understand that the following are requirements to be an oocyte donor and we represent that we meet each of the requirements.

1. The oocyte donor is between the ages of 18 and 35.
2. The oocyte has medical insurance.

We acknowledge and agree that our acceptance into the program and our continuing participation is at the discretion of the staff of the program. The oocyte donor agrees to abstain from all sexual activity, including intercourse. We understand that if we do engage in sexual activity at or about the time of the egg retrieval without barrier contraception, there is a risk that I may become pregnant with my eggs that may not have been collected at the time of the egg retrieval. If pregnancy does occur, we release C.C.R.E.I., the In Vitro Program and Prakash Thiruppathi, M.D. from any liability or responsibility related to the pregnancy. We also release

the prospective parent(s) of the donated oocytes from any responsibility or claim related to the resulting pregnancy.

We agree to adhere to all medical instruction given by the physician or nurse.

The oocyte donor agrees not to drink any alcoholic beverages, not use any illegal drugs, not to use any non-prescription medications or prescribed medication without the knowledge of and consent from the physician, commencing one month prior to donating eggs.

I understand that by participating as an oocyte donor I am required to undergo testing such as drug screening, psychological evaluation and hormone levels. Once these tests are performed and are perceived to be adequate, my profile will be given to prospective parent(s). I understand that I may be able to be a donor as many as four times however, I am not obligated to do so.

**Description of Procedures**

I understand that, if I am employed, I must make arrangements with my employer to take time off work and be available for these medical procedures. I also understand that I may need to be available for longer periods of time if medical procedures require.

**Oocyte Stimulation**: Prior to this time, I will be taught how to administer several types of medication to promote the simultaneous maturation of multiple oocytes in my ovaries. During this time, I understand that I am required to be available for blood work and ultrasound 6-10 times within a 12 day period. These appointments could take up to 30-45 minutes per day. I understand these appointments are extremely important so the physician can monitor my response to the medications.

**Egg Retrieval**: Once my eggs have reached a mature size for fertilization, I will be instructed to administer the HCG injection. In understand that egg(s) from the ovary(ies) will be taken from me by means of Transvaginal Culdocentesis (a procedure in which a long needle is utilized under sonographic control to aspirate eggs from the ovaries). This procedure is performed while the patient is sedated by a Board Certified Anesthesiologist. After the eggs are retrieved, they will be inseminated with the male prospective partner, known or anonymous donor sperm in hopes to create an embryo(s). In some cases, a micromanipulation procedure (Intracytoplasmic Sperm Injection) will be utilized for fertilization. After the embryos have bee incubated for three to five days, the physician will implant the designated number of viable embryos into the female prospective parent or surrogate carrier's uterus through the vagina and cervix.

We understand that there are no assurances that sufficient number of eggs will be retrieved, that developing fertilized eggs can be created or that implantation or subsequent pregnancy in the recipient will be successful.

**Risks of IVF**

As with other procedures, it is conceivable that there are risks which cannot specifically be identified. The physician may fail to retrieve the eggs either because my ovaries did not respond to the stimulation or because they could be collected due to technical problems, however, the potential side effects have been explained to me and are outlined below.

**Fertility Medications**: The most common side effect is increased stimulation to the ovaries. Twenty percent of patients receiving fertility medications can incur ovarian enlargement, which causes pain due to abdominal distention, but to those treated, the problem is generally resolved on its own in about one week. Severe ovarian enlargement, known as Hyperstimulation Syndrome, can cause accumulation of fluid in the abdomen and lungs and can cause breathing difficulties. The fluid difficulties can cause increased clotting in the blood, which could be life threatening. Fortunately, Hyperstimulation Syndrome only occurs in 1-2% of patients undergoing treatment. Hospitalization may occur in severe cases. Patients using fertility medications may have reactions such as pain, rash, swelling at the injections site and ectopic pregnancy. The HCG injection can cause headaches, irritability, restlessness, depression and fatigue. Lupron can cause menopausal symptoms such as hot flashes. Some recent studies have suggested that fertility medications may increase the risk of ovarian cancer. These studies involve a small number of patients and the results cannot be wholly accepted. Other studies have also been done which do not agree with the increased risk.

**Egg Retrieval**: Transvaginal Ultrasound Guided Needle Aspiration of the eggs carries the possibilities of bleeding, infection and injury to the bladder or abdominal structures that may require surgery, either immediately or in the future. Infection may further impair fertility or result in a loss of fertility potential.

**Treatment Decisions**

We understand that all decisions regarding each step of the procedure involved such as stimulation, fertilization and implantation will be made by our physician based on his individual medical judgment. We understand that our physician may decide not to proceed with the procedure because of possible complication or risks to the patient, husband or potential child.

**Legal Status**

We understand that due to the relatively new nature of In Vitro Fertilization with anonymous oocyte donor, many legal issues surrounding the procedure have not been resolved and the legal status of any resulting child in terms of legitimacy or otherwise is uncertain. It is our intent and understanding that any resulting child be the legitimate child of the prospective parent(s) and that neither I, as the egg donor, or my husband will ever attempt to form a parent-child relationship with any child or children that may be born as a result of the implantation of the embryos into the female prospective parent or surrogate. We understand that once the egg retrieval has been performed, my participation has ended and we waive our rights or responsibility to any resulting children. We also understand that if the prospective parent(s) chose to cryopreserve any or all resulting embryos, we relinquish all rights to claim responsibility to those embryos.

We understand that as an Egg Donor that my anonymity is required as well as the Prospective Parent(s). The Prospective Parent(s) have a signed consent and agreed not to try,

under any circumstances, to contact me or my family and are aware that absolutely no identifying information will be given to them from this program concerning me. The only information the Prospective Parent(s) have received is a summary of my medical, genetic and social history. The Prospective Parent(s) have agreed to be fully responsible for any and all embryos resulting from my donation.

**Medical Expenses**

We understand the risks involved with participating in the In Vitro Fertilization program. We understand that our physician and medical facilities are available for treatment. We understand that we must have medical insurance which is current and offers major medical treatment. We understand that the Columbus Center for Reproductive Endocrinology and Infertility is not financially responsible for any treatment that is not outlined in the procedure section of this consent form.

**Financial Consideration**

The prospective parent(s) will be solely responsible for any and all medical cost of the Egg Donor resulting from the procedure and any and all complication that may arise as a result of this treatment.

**Confidentiality**

We understand that many safeguards have been taken to keep our names anonymous and these safeguards have been disclosed to me. We are also aware that even though these precautions have been taken, my identity may be revealed by error or when C.C.R.E.I. is compelled by law. We understand that should the results of my treatment or any aspect of it be published in medical or scientific journals, all reasonable precautions will be taken to protect my anonymity.

We understand and acknowledge that the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. or their staff, employees or agents have not undertaken hereby or in any other document or oral communication to advise me of my legal rights, now existing or hereafter arising and specifically disclaim any responsibility to do so. We understand that the Columbus Center for Reproductive Endocrinology & Infertility recommends that we consult legal counsel so as to be fully informed of our legal rights and obligation of others involved in this procedure, but if we elect not to do so, such election is hereby acknowledged to have been determined without reliance upon statements, oral or written of the Columbus Center for Reproductive Endocrinology & Infertitlity, L.L.C., the physician, the staff, employees and agents.

We agree that I will be compensated, upon completion of the Egg Retrieval, for my time and effort. A total of $3000 will be provided for my services as an anonymous egg donor if I complete the program. If I cannot complete the egg donor process, I understand that I will be paid $30.00 a day for each day I did participate, commencing on the day of the first gonadotropin injection. I have provided the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. with my social security number since such compensation is subject to usual taxation, which is my responsibility. The reimbursement is for my time and effort for participating in the program and is not payment for my eggs.

We hereby release and discharge the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C., the physician, staff and all representatives from any all claims and demands, actions and causes of action, damages (either direct or consequential) which we may have against the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. as a result of my participation in the Egg Donor Program. We fully understand and without reservation accept all risks, known and unknown, of my participation in this program.

We voluntarily consent and agree to participate in the Egg Donor Program. I have read and understand all material the Egg Donor Program at the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C. concerning the treatment and all risks. Our involvement, the risks, and inconveniences of the treatment have been explained to our satisfaction and we have both had the opportunity to ask any questions and such questions have been answered to our satisfaction.

| | |
|---|---|
| _____ | _____ |
| Donor's Signature | Spouse's Signature |
| _____ | _____ |
| Donor's Printed Name | Spouse's Printed Name |
| _____ | _____ |
| Time & Date | Time & Date |
| _____ | _____ |
| Witness' Signature | Witness' Printed Name |

_____
Date & Time

**Physician's Signature**

I, the patient's physician, or his/her representative, verify that the matters referred to in the above consent and release form have been explained to both the Donor and spouse, that any necessary information concerning the In Vitro Fertilization Program, the risks and uncertainties associated with such programs. All questions have been answered to their satisfaction.

| | |
|---|---|
| _____ | _____ |
| Prakash Thiruppathi, M.D. | Date & Time |