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 $2500 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