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DONOR EGG PROGRAM

Dear Prospective Donor,

We appreciate your interest in our program. On the following pages, you will find an application and information about egg donation. The process of becoming an egg donor involves a series of psychological and medical screening. Psychological screening, involves approximately 2-3 office visits with our program's social worker. Medical screening involves approximately 2 appointments: the first is an ovarian volume (vaginal sonogram and blood testing for hormone levels), and the second is a physical exam, pelvic exam, drug testing, and blood tests for communicable diseases and genetic disorders. In addition, your significant other will need to see the social worker. You will make all of your donor screening appointments at **no** cost to you. Once your screening is complete, you can be anonymously offered to an intended parent/couple for selection.

Once you are selected, the donor cycle involves two of your menstrual cycles. Once you begin stimulation for a donor cycle, you will need to come in to one of our monitoring offices in the mornings (between 6:30am-8:00am) for blood work and sonograms for approximately 10 days. There will also be a day that you will need to come in to Long Island IVF's Ambulatory Care Site, located at our Melville facility, for retrieval (harvesting of eggs). You are given anesthesia via IV sedation for this procedure, and you may resume normal activities the following day. We will see you again after your next period for a resolution sonogram, to look at your ovaries and uterus. You may be eligible to donate up to six times for our program. You will be compensated for your time and effort spent going through a donation cycle. All donors will be compensated \$8,000.

If you are interested in proceeding after reviewing these materials, please complete the application and medical history by hand (not typed) and return them to us. **DO NOT WHITE OUT ANYTHING OR WE CANNOT ACCEPT IT.** Once you are accepted as a donor, we take your application, remove all of the identifying information, and assign you an anonymous number. Your application is then shown to intended parents, for possible selection. Therefore, please complete as much of the application as you possibly can. Please ask your parents and extended family for help filling out the family health history sections, if you are unsure of any of the answers to those questions. Spelling and punctuation ARE important. When looking at the medical information on the extended family and there is nothing wrong (**YOU MUST CHECK NO ONE**). The personal sections help the intended parents sense what kind of person you are, and how much thought was given to why you want to donate. If any questions arise while filling out the application, please do not hesitate to contact a member of the Donor Egg Team for assistance (631-881-5324). Also, if you have medical records pertaining to any medical conditions, please enclose them for us to review. As you might expect, the physical health of a donor is very important. We will review your application and screen it according to strict medical criteria. When the review is complete, we will contact you. Again, thank you for your interest in helping infertile couples.

Sincerely yours,
Victoria Loveland, R.N. - Donor Egg Clinical Coordinator

The Facts About Egg Donation

Egg donation helps infertile women. It allows fertile women to give a number of eggs to a woman who is unable to get pregnant with her own eggs. Egg donation uses the same techniques as in vitro fertilization (IVF), where the union of the egg and the sperm take place in a laboratory rather than in the body. In order for this to occur, the eggs must be removed from a woman's ovaries. The removal process is called retrieval.

Preparation for egg retrieval begins with a birth control pill. When the birth control pill is stopped, stimulation begins by taking medication to stimulate the ovaries. Then, towards the end of your stimulation, while the eggs are maturing, a medication called Ganirelix is prescribed to keep you from ovulating prematurely.

When the eggs are mature, retrieval is scheduled. Prior to the procedure, there will be one final injection of a different medication (hCG or Ovidrel) which directs the ovaries to release the eggs.

Egg retrieval is performed at our Melville facility in the ambulatory surgery suite, under local anesthesia and intravenous sedation. While the donor is asleep, the physician uses an ultrasound-guided catheter to remove the eggs transvaginally. The entire procedure will take from one-half to three-quarters of an hour. The donor will recover from the sedation, and then have someone drive her home to rest for the remainder of the day. A compensation check will be given to the donor after completion of the procedure.

Although we don't expect any complications following the procedure, each donor is scheduled for a post-retrieval resolution sonogram with her first bleed following retrieval. This is to confirm that her ovaries are returning to their natural state, which can take up to several weeks. It is advised that donors abstain from intercourse until after their resolution sonogram.

LONG ISLAND IVF
DONOR EGG PROGRAM

Please complete the enclosed abstract, and please be completely candid. A “yes” response will not necessarily eliminate you as a potential donor. Many women will have at least one of these conditions in herself or a family member. The accuracy of the information you will be giving will influence greatly on the future generations you are about to help create.

The Donor Egg Team will thoroughly review your application, and if accepted, a portion of your statements will be made anonymous and then circulated amongst our patients. If you do not wish the information in this packet to be made available to our patients, please let us know. This information will not be divulged without your permission. However, if you choose not to share this information with our patients, you will not be allowed to donate with our program.

To reiterate, this information will remain a confidential part of your medical record unless you agree to allow us to share it with our patients. Please answer all questions openly and honestly.

Are you a citizen of the United States? Yes _____ No _____

Some people cannot provide a complete family history (including grandparents). For example, if you are adopted, or do not know one side of your family, your ability to provide a complete family history may be compromised. Is there any reason you cannot complete a family history?

Yes _____ No _____ If yes, please explain: _____

How did you hear about our program (please be specific with the name of the newspaper, radio station, movie theater, etc. where you saw/heard our ad, or with the name of the person who referred you)? _____

Have you ever been an egg donor before? Yes _____ No _____

If yes, where and how many times? _____

_____ Plea

se describe any concerns or complications from prior donations: _____

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Long Island IVF to release to my insurance carrier records pertaining to my medical history, services rendered, or treatment given to me.

Signature _____ Date _____

Please send your completed application to:

**Long Island IVF Donor Egg Program
8 Corporate Center Drive, Suite 101, Melville, NY 11747**

CHEEKBONES:

Set	low	average	high
Prominence	slight	medium	strong

MOUTH:

Size	small	average	large
Lips	thin	average	full

CHIN:

Shape	square	oval	round	
Prominence	slight	average	strong	
Cleft	none	slight	medium	strong

SKIN:

Tone	light	med-light	medium	med-dark	dark
Tanning ability	none	slight	medium	easy	
Condition	oily	medium	dry	combination	
Acne	none	slight	medium	severe	

At what age: _____

OTHER FACIAL FEATURES:

Moles	none	one	several	numerous	where: _____
Freckles	none	several	moderate	numerous	where: _____
Dimples	none	slight	medium	deep	where: _____

PHYSICAL AIDS:**EYES:**

Vision	normal	far-sighted	near-sighted	
Glasses/Contacts	none	single	bifocal	trifocal

Age Diagnosed _____ yrs. old

Lasic/Laser Eye Corrective Surgery: Y / N **When:** _____

DENTAL:

Device	none	braces	retainer	other _____
Reason	cosmetic	accident	disease	other _____

Age during use: _____ to _____ years of age

OTHER:

List: _____

Reason (cause): _____

RELIGION

Are you an: atheist _____ agnostic _____

What religion did you belong to as a child? _____

As an adult? _____

How religious are you now? Very _____ Moderately _____ Occasionally attend _____ Not at all _____

EDUCATION

Completed grade school: _____ Completed high school: _____

Currently in college, pursuing a degree in: _____

Completed college degree in: _____

Currently pursuing an advanced degree in: _____

Completed an advanced degree in: _____

LANGUAGES

Speak: _____ **Read:** _____ **Write:** _____

ATHLETIC ACTIVITY (circle appropriate choice)

athletic active average inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____

MANUAL DEXTERITY (circle appropriate choice)

dexterous average clumsy

What manual skills do you have? _____

What other skills or talents do you have (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe: _____

MUSICAL ABILITY (circle appropriate choice)

Musical average tone deaf

WORK HISTORY/OCCUPATION HISTORY

What were your strengths in school? _____

What were your weaknesses in school? _____

Were you ever diagnosed with any learning disabilities? _____

What is your current or most recent occupation?* _____

What other types of employment have you had?* _____

*(Please DO NOT list employers, or company names; only your occupation/job title)

REPRODUCTIVE HISTORY

Have you ever been pregnant? Yes _____ No _____ If yes, how many times? _____

How many live births? _____ How many abortions? _____

CHILDREN

AGE	HAIR COLOR/TYPE	EYES	SKIN-TONE

PERSONAL HISTORY/PERSONAL CHARACTERISTICS

Current allergies? Yes _____ No _____ If yes, to what? _____

How long? _____ Any treatment given? _____

Describe any weight problems you may have had: _____

Diet: Describe your preferences and dislikes: _____

Do you drink alcoholic beverages? Yes _____ No _____ If yes, what kind? _____

How many drinks (beer, wine, alcohol) do you consume on average per: day? _____ week? _____ month? _____

*Have you ever sought help for an alcoholic problem? If yes, please explain: _____

If you do not drink at all, what is your reason? _____

Have you ever been convicted of a crime, or at present, have any pending legal action?

Yes _____ No _____

Describe yourself as a child (e.g., personality, health, interests, activities, etc.): _____

What are your favorite foods? _____

What is your favorite color? _____

Do you like pets? If so, which is your favorite? _____

To where would you most like to travel and why? _____

How would you describe your personality? _____

What is your ultimate ambition or goal in life? _____

What were your reasons for becoming a donor?

What would you especially like your genetic offspring to know about you (if anything)?

Would you be willing to be contacted by Long Island IVF in the future, if your genetic offspring needed further genetic or medical information?

Yes _____ No _____

FAMILY HISTORY

Please complete the chart below for each of your immediate family members. Please circle Brother or Sister to specify the gender of the sibling you are referring to. Please fill in each family member's current age (**or** age at death). Please list any medical problems they have currently (and/or their specific cause of death), **AND any medical problems they may have had in the past**. Be sure to list any brothers or sisters who may have died in infancy. *Please ask your family members if you are unsure about their medical history.*

family member	age (IF ALIVE)	Medical Problems	Age of Death (if applicable)	Cause of death (if applicable)
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Brother / Sister				

What is your ethnic background? (Please check and circle all that apply. If none apply, please write in next to *Other*.)

- _____ Northern European (Ireland,Denmark,Finland,UK,etc.)
- _____ Western European (Austria, France, Germany, etc.)
- _____ Eastern European (Russia,Poland,Hung.,Czech R.,etc.)
- _____ Southern Europe (Italy, Spain, Portugal, etc.)
- _____ Southeast Asian (Cambodia, Vietnam, etc.)
- _____ Far East Asian (China, Japan, Philippines, etc.)
- _____ Middle Eastern (Iran, Israel, Syria, Egypt, etc.)
- _____ Ashkenazi Jewish / Sephardic Jewish

- _____ African
- _____ Indian
- _____ South American (Brazil, Peru, Argentina, etc)
- _____ West Indies / Caribbean
- _____ French Canadian / Cajun
- _____ Puerto Rican
- _____ Dominican Republic
- _____ Mexican
- _____ Native American

***When completing the family history section on the following pages, please DO NOT write the names of your family members or the names of their places of employment (for Occupation: just list their job title/type of employment, for example: office clerk, bank manager, or school teacher, etc.).**

MOTHER: Place of birth: _____
Racial group: _____
Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

Other distinguishing features: _____

Occupation: _____

Education: _____

Special skills, characteristics, achievements: _____

Describe her personality: _____

RED # _____

FATHER: Place of birth: _____
Racial group: _____
Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

Other distinguishing features: _____

Occupation: _____

Education: _____

Special skills, characteristics, achievements: _____

Describe his personality: _____

SIBLING: Brother _____ Sister _____

Place of birth: _____

Racial group: _____

Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

Other distinguishing features: _____

Occupation: _____

Education: _____

RED # _____

Special skills, characteristics, achievements: _____

Describe her/his personality: _____

SIBLING: Brother _____ Sister _____

Place of birth: _____

Racial group: _____

Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

Other distinguishing features: _____

Occupation: _____

Education: _____

Special skills, characteristics, achievements: _____

Describe her/his personality: _____

SIBLING: Brother _____ Sister _____

Place of birth: _____

Racial group: _____

Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

RED # _____

Other distinguishing features: _____

Occupation: _____

Education: _____

Special skills, characteristics, achievements: _____

Describe her/his personality: _____

SIBLING: Brother _____ Sister _____

Place of birth: _____

Racial group: _____

Religion: _____

Age: _____ Height: _____ Weight: _____ Eye Color: _____ Natural Hair Color: _____

Complexion: _____ Body Type: _____ Bone structure: _____

Other distinguishing features: _____

Occupation: _____

Education: _____

Special skills, characteristics, achievements: _____

Describe her/his personality: _____

FAMILY HISTORY (continued)

Has any member of your family, including yourself, had a problem or defect **AT BIRTH** in any of the following body systems:

- | | | |
|--|-----------|----------|
| 1. Organ (heart, lung, kidney, etc.) | Yes _____ | No _____ |
| 2. Blood circulation | Yes _____ | No _____ |
| 3. Respiratory system | Yes _____ | No _____ |
| 4. Gastrointestinal system | Yes _____ | No _____ |
| 5. Genital/Urinary | Yes _____ | No _____ |
| 6. Metabolic (hormones, enzymes, etc.) | Yes _____ | No _____ |
| 7. Nervous system, brain, spinal cord | Yes _____ | No _____ |
| 8. Bones, muscles, joints, limbs | Yes _____ | No _____ |
| 9. Cleft Lip / Cleft Palate | Yes _____ | No _____ |
| 10. Other: _____ | Yes _____ | No _____ |

If yes to any of the above, please list below the specific defect in each case.

Type of Defect	Affected Family Member	Relevant Circumstances
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any diseases, abnormalities or conditions that appear to run in your family?

Yes _____ No _____

If yes, please indicate the disease(s) and the family members affected: _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious). Yes _____ No _____

If yes, please explain: _____

DONOR EGG PROGRAM

Risk Factor Questionnaire

Name:

Signature:

Date of Birth:

	Yes	No	Don't Know	Comments
1. Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection?				
2. Do you have a clotting disorder for which you have received human-derived clotting factor concentration? Or had sex with anyone who has?				
3. Have you had sex for drugs or money in the past 5 years?				
4. In the past 12 months, have you given money or drugs to anyone to have sex with you?				
5. Have you had sex in the past 12 months with anyone who would answer yes to the above 4 questions?				
6. In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?				
7. In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?				
8. In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin or mucous membrane?				
9. In the past 12 months, have you been in close contact ,or had sex with or shared a kitchen or bathroom with a person having active viral hepatitis?				
10. In the past 12 months, have you had tattooing, ear or body piercing? If so, please give dates.				
11. After the age of 11, have you ever had viral hepatitis?				
12. Have you yourself received or had intimate contact (i.e. exchanged bodily fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?				
13. Have you had or been in contact with anyone who has had a recent small pox vaccination?				
14. Have you been diagnosed with West Nile Virus?				
15. Have you had a headache and a fever within the last 7 days?				
16. In the past 12 months, have you had acupuncture, electrolysis, an accidental needle stick, or a sharp instrument injury? If so, please give dates.				
17. Have you ever received growth hormone made from human pituitary glands or any blood products?				
18. Have you ever received a dura mater (brain covering) bone or skin graft? Give dates.				
19. Have any of your blood relatives ever had Creutzfeldt-Jacob disease or any neurological disease?				
20. In the past 12 months, have you had a positive syphilis test?				
21. In the past 12 months, have you had or been treated for syphilis, gonorrhea, or Chlamydia?				
22. Have you ever been in jail? For how long?				
23. From 1980 through 1996, were you a member of the US military, a civilian military employee, or a dependent of a member of the US military?				

24. In the past 3 years, have you ever been outside of the United States? Where and When				
25. Since 1980, have you ever lived in or traveled to Europe? (<i>Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar or the Falkland Islands</i>) Give dates.				
26. Have you ever been in a place affected by SARS (i.e., China) or been treated or been with an affected person in the past 14 days?				
27. Were you born in, have you lived in, or have you traveled to any African country since 1977?				
28. Have you had sexual contact with anyone who was born in or lived in any African country since 1977?				
29. Have you had a blood transfusion?				
30. Have you ever been diagnosed with T.cruzi or Chagas?				

I have reviewed all risk factor questions and verify my answers to be true:

Donor Signature: _____ Date: _____

DE Coordinator Review Signature: _____ Date: _____

DONOR EGG PROGRAM

I, _____, have carefully read and answered all of the questions in this donor egg application. My responses are true and correct to the best of my knowledge. In addition, with the exception of all personally identifying information, I have agreed to allow Long Island IVF, P.C. (“Long Island IVF”) to share a portion of this application that contains potentially-identifying information about me (pages 1-13 of this packet, referred to as the “Abstract”), with intended parents. Although the Abstract does not contain my name, date of birth, or address, etc. it may be possible for someone to identify me based on the combination of other information disclosed in the Abstract. I, therefore, waive my rights to privacy under HIPAA and any other pertinent federal and state laws concerning privacy and/or confidentiality. I also hereby release and forever discharge Long Island IVF, its directors, officers and employees from and against any claims stemming from the provision of the Abstract to any intended parents. I further understand that while Long Island IVF will avoid disclosure to every extent possible, intended parents and donors assume the risk of identification via participation in this program.

Potential Donor’s Signature _____ Date _____

If you have any comments or concerns, please feel free to share them with us:

Comments: _____

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