



Thank you for your interest in becoming an Oocyte (egg) Donor with Carolina Conceptions!

The goal of our program is to provide eggs anonymously to women with impending or complete ovarian failure. Ovarian failure is one of the leading causes of infertility and may occur for many reasons. Delayed child-bearing, radiation or chemotherapy for cancer, autoimmune diseases and surgical removal of the ovaries are a few of the causes of ovarian failure. Donor oocytes provide couples with little or no chance of achieving a pregnancy a 2 in 3 chance of conceiving each cycle.

Donating eggs is not an easy process and will require a commitment of time and energy. Couples with whom you may be matched will be investing approximately \$20,000 for each cycle; therefore, it is important that you are willing to completely commit to the process once begun. Please let us know if at any time you decide that you are unwilling to participate in this program.

We will utilize the information you have provided in this form to determine if you are an appropriate candidate to complete the screening to participate in our program. If appropriate, we will contact you by phone and arrange a day for you to complete the screening process. During a cycle you will be required to give yourself several injectable medications. You may choose to have a friend or partner administer these medications. We will instruct you on how to give these medications and provide them for you. All of the medications are very important for the success of the cycle and it is crucial that they be administered as directed. We will also discuss and ask you to sign consent forms and will obtain a blood sample to screen for blood type, HIV 1 and 2, hepatitis B core antibody and surface antigen, hepatitis C, RPR (syphilis), rubella (German measles), and varicella (chicken pox) immunity as well as Chlamydia, Gonorrhea, Cystic Fibrosis and sickle cell as indicated. This is a guideline provided to us by the FDA and must be completed and negative, within a specific time frame of the actual donation in order for you to proceed. You will also meet with Betty-Shannon Prevatte, a licensed Clinical Psychologist, who will talk with you about why you want to be a donor and address any concerns or questions that you may have regarding your decision to be an egg donor. She may administer a psychological test as well. Once a tentative match has been made we will contact you by phone to ask if you are still willing to be a donor and if there are any dates that you would not be available.

After all this screening you may discover that you have not been accepted as an egg donor. This does not mean that there is anything wrong with you. We are concerned about many issues including the possibility that you may regret your participation. Once all of the screening is complete we will attempt to match you with a recipient couple and schedule the start of the medications.

Oral Contraceptives:

Once matched, if you are not currently using a form of birth control, you will be instructed to do so at this time. Please contact the donor coordinator with the onset of your menses. You will remain on the active oral contraceptives for 14-21 days. The start and stop dates will be outlined and specified for you.

Gonadotropins

Gonadotropins is the term used to describe the medication(s) that will be used to stimulate your ovaries to produce multiple mature eggs in a cycle. They are simply a lab created version of a hormone that occurs naturally in your body. These need to be given every evening from 9-18 days (the average time is 12 days). They are administered subcutaneously (just under the skin) and need to be administered at the same time each day. Again, all of these medications will be provided to you and you will be instructed on how to administer and store them appropriately. Your dose will be very specific to you and will be provided to you at the time of your education session with the nurse. Before taking these injections we will need to complete a vaginal ultrasound to assess your ovaries before you start taking the injections. After taking 4 injections of your gonadotropin you will need to come to the office for a monitoring visit. Our monitoring visits take place early in the day, beginning at 7:30, and consist of a trans-vaginal ultrasound and blood estrogen level. This enables us to determine how you are responding to the medication and whether or not we need to adjust your medication dosage. We will discuss your progress with you and make arrangements for your next visit. You should expect to see us every 2-3 days for 3 or 4 visits. Our patient load can be variable and sometimes waiting cannot be avoided. We recommend that you bring reading materials or other distractions.

Once your follicles (cysts containing eggs) on your ovaries have reached the desired size you will be asked to administer an additional medication called Antagon.

Antagon (Ganirelix)

Antagon is an injection that is also administered subcutaneously (just under the skin). It is given in conjunction with your gonadotropin in an attempt to prevent premature ovulation. Once you begin taking this medication you will take it every day until instructed otherwise. You will typically take this medication between 1-4 days.

Ovidrel (human chorionic gonadotropin)

We will instruct you to take Ovidrel in the evening 2 days prior to egg retrieval. This medication is also given subcutaneously. It is very important that you take this injection at the exact time instructed as we will plan the egg retrieval 36 hours later. Ovidrel will cause the eggs to become fully mature. After the Ovidrel, you will not take any more injections.

Egg retrieval

On the morning of your planned egg retrieval you will be instructed to arrive 30 minutes prior to your retrieval time. You will need to bring a current photo ID and plan to wear comfortable loose fitting clothing with flat shoes, no jewelry or heavily scented lotions / perfume. You will not be able to drive yourself home on this day. Please make arrangements for transportation to and from the clinic. You should also plan on having someone with you throughout the day to be your responsible care provider. When you arrive at the clinic, you will be asked to change into a gown for the procedure then taken to the recovery / holding area. You will place your clothing items in a locker; however we ask that you not bring any valuables with you. The nurse anesthetist will then review your medical history with you and place your IV. When it is time for the retrieval, you will be transferred to the procedure area. Dr. Meyer, Couchman or Park will perform your

egg retrieval while the nurse anesthetist administers your IV anesthesia and monitors you during the retrieval. The typical retrieval lasts 10-20 minutes depending upon the number of follicles to be retrieved. It is normal to experience blood tinged vaginal discharge after this procedure.

We will not be able to remove all of the eggs during this procedure which means you could easily become pregnant from this cycle. We strongly suggest that if you are sexually active you use barrier contraception (diaphragm, condoms). It would be preferable to abstain until after you have a period. You should expect that after your donation, your period will start in 10-14 days. At this time you may return to your normal form of contraception – if using oral contraceptives please be aware that you will need to complete one full pack of pills before they are effective.

There are several complications that may occur while participating in a cycle of egg donation. The primary ones to be aware of include Ovarian Hyperstimulation Syndrome (OHSS) and the possible risk of developing ovarian cancer later in life as a result of use of infertility medications. Newer studies suggest that the risk of ovarian cancer is not increased by the use of gonadotropins. Use of birth control pills and pregnancy can both decrease your risk. We would be happy to answer any questions that you may have. The risk of Ovarian Hyperstimulation exists anytime these medications are used. Most people will feel bloated; have some abdominal tenderness and may notice transient weight gain while using these medications. In severe cases, patients may require IV fluids, pain medication, hospitalization and monitoring to prevent severe medical complications. This occurs rarely (1%) of the time. If you have regular periods you are not at high risk for developing severe ovarian hyperstimulation syndrome.

You may donate more than one time. However, current guidelines support no more than 6 donations during your lifetime. If you do decide to complete additional cycles you will be required to meet acceptance guidelines for our program and we will ask you to re-sign consent forms, and have labwork done prior to each subsequent donation.

We hope this brochure has answered any questions you may have regarding becoming an egg donor. Please feel free to call our office if you have additional questions at (919)-782-5911 ext. 108

If after reading this information you are still interested in becoming an egg donor, please complete the following medical history forms and submit them to our office:

Carolina Conceptions
Attn: Oocyte Donor Coordinator
2601 Lake Drive Suite 301
Raleigh, NC 27607

Date _____

Name (first, middle, last) _____

Home Phone _____

Address _____

Work Phone _____

Cell Phone _____

Which number is the best to reach you? _____

Which number(s) may we leave messages for you? _____

E-mail Address _____

Occupation _____

Work Address _____

Emergency contact name and phone number:

Date of Birth _____ Social Security Number _____

Marital Status: single married divorced widowed

Husband / Partner's Name _____

Date of marriage or length of relationship _____

Is your partner aware of your interest in donating?

Have you donated eggs previously? Yes No

If yes, please provide dates and location(s) of donation(s) with name of clinic and physician(s) with number of eggs retrieved, medication dose and name:

How did you find out about egg donation? _____

Are you currently taking any medications? _____

Are you currently sexually active? Yes No

How many sexual partners have you had in your lifetime? Male_____ Female_____

In the past six months?_____

What is your current method of birth control?_____

Do you receive regular gynecologic care?_____

When was your last pap smear?_____

At what age did you start having periods?_____

Are your periods regular without birth control?_____

Have you ever been pregnant? Yes No

If so, what was the outcome?_____

Have you or your partner(s) ever been screened for or diagnosed with a sexually transmitted disease? If so, please specify and indicate dates and or treatment._____

Do you smoke cigarettes? Yes No

How much?_____

How often?_____

Do you drink alcohol? Yes No

How much?_____

How often?_____

Do you take any recreational drugs? If so, please specify:_____

Have you been hospitalized for any medical treatment(s)? Yes No

If yes, please specify_____

Have you been evaluated or treated by a licensed mental health professional? Yes No

If yes, please specify_____

Please describe your ethnic background: _____

Do you have any Greek or Italian ancestors?	Yes	No
Have you ever been screened for Thalessemia?	Yes	No
Do you have any Jewish ancestors?	Yes	No
Have you been screened for Cystic Fibrosis?	Yes	No
Have you been screened for Tay Sach's disease?	Yes	No
Do you have any African American Ancestors?	Yes	No
Have you been tested for Sickle Cell disease?	Yes	No

How many brothers and sisters do you have? _____

What is your rank in birth order? _____

Are there any dominant physical characteristics that run in your family? (such as curly hair, freckles, tall, etc.)? _____

Height: _____ If over 21, weight at age 21: _____ Current weight: _____

Natural hair color: _____ Current hair color: _____

Hair texture: curly straight wavy
coarse fine thick thin other: _____

Skin: Fair medium olive light brown
dark brown freckled other: _____

Eye Color: _____

Do you currently have health insurance? _____

Do you wear glasses or contacts? _____

Have you ever worn braces? If yes, how long? _____

Do you currently receive routine dental care? _____

Do you consider yourself physically active? _____

Please describe your current diet and exercise routine: _____

Do you have any special talents or abilities in art, music, athletics, language(s)?

Please list dates and locations of all your academic degrees, starting with high school:

Did you receive any academic honors or awards, or excel in any particular subject in school? Were you a member of any clubs or athletic teams? If so, please describe:

To the best of your ability, describe your personality. For instance are you more reserved or outgoing?

Please describe your likes and dislikes, how you spend your free time, etc. You may include your favorite movies, books, music, hobbies or any other topic that interests you.

Why do you want to be an egg donor?

May we contact you in the future should there ever be a serious health problem with any child or children produced from this process? _____

Would you be willing to contact us to inform us of any serious change(s) in your health condition or changes in that of your immediate family? _____

Please list things you would like us to know about you as an egg donor:

Genetic History
Your Father's Family:

Your Father: Living? Yes No
If Yes, age? _____
If No, age of and cause of death _____
Any health problems and age diagnosed: _____

Your Paternal Grandfather: Living? Yes No
If Yes, age? _____
If No, age of and cause of death: _____
Any health problems and age diagnosed: _____

Your Paternal Grandmother: Living? Yes No
If Yes, age? _____
If No, age of and cause of death _____
Any health problems and age diagnosed: _____

Any Aunts/Uncles on your Father's side

Sex	Living?	Age (current or at death)	Health problems?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Mother's Family:

Your Mother: Living? Yes No
If Yes, age? _____
If No, age of and cause of death _____
Any health problems and age diagnosed: _____

Your Maternal Grandfather: Living? Yes No
If Yes, age? _____
If No, age of and cause of death: _____
Any health problems and age diagnosed: _____

Your Maternal Grandmother: Living? Yes No
If Yes, age? _____
If No, age of and cause of death _____
Any health problems and age diagnosed: _____

Any Aunts/Uncles on your Mother's side

Sex Living? Age (current or at death) Health problems?

Your Siblings - Brothers and Sisters

Sex Living? Age (current or at death) Health problems?

Your Children

Sex Living? Age (current or at death) Health problems?

Please carefully review the following list of medical problems and identify any that are present in the listed family members. Place a check in the box if they apply:

Condition	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
BLOOD ISSUES							
Anemia							
Sickle-cell anemia							
Hemophilia							
Leukemia							
HIV Virus							
Cancer							
Lymphoma							
Other							
CONGENITAL ABNORMALITIES	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Cleft lip / palate							
Hip problems							
Club feet							
Cri du chat							
Trisomy 18							
Trisomy 13							
Fragile X							
Other							
GASTRO-INTESTINAL	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Ulcer of the stomach or duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Intestinal cancer							
Developmental disorders of stomach and intestine							
Pyloric Stenosis							
Rectal disorder							
Any other cancer or problem of digestive system							
GENITAL / REPRODUCTIVE	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Undescended testicle							

Hermaphroditism / ambiguous genitals							
Hypospadias							
Prostate cancer							
Testicular cancer							
Lumps or cysts in breasts							
Breast surgery							
Two or more miscarriages							
Stillborn							
Death of a newborn infant							
Neonatal jaundice							
HEART	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Stroke							
Heart attack							
Heart disease							
Hardening of the arteries							
High blood pressure							
High cholesterol level							
Other							
MENTAL HEALTH	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Schizophrenia							
Manic depressive or Bipolar disorder							
Anxiety / panic attacks							
Mild depression							
Other							
METABOLIC / ENDOCRINE	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Diabetes mellitus							
Hypoglycemia							
Thyroid cancer							
Thyroid disease							
Goiter							
Adrenal dysfunction of disorder							
Hyperactivity							
Other							
MUSCLE/BONE/ JOINTS	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin

Muscular dystrophy							
Loss of muscle disease							
Loss of muscle coordination							
Lupus							
Osteoporosis							
Dwarfism							
Arthritis							
Gout							
Myasthenia gravis							
Other							
NEUROLOGICAL	You	Mother	Father	Sibling	Grandparent	Aunt /Uncle	Cousin
Migranes							
Mental retardation							
Down syndrome							
Alzheimers disease							
Senility before age 50							
Multiple sclerosis							
Cerebral palsy							
Epilepsy / seizures							
Hydrocephalus							
Spina bifida / Neural tube defect							
Huntingtons disease							
Gauchers disease							
Wilsons disease							
Parkinsons disease							
Paraplegia							
Tourettes syndrome							
Scoliosis							
Other diseases of the nervous system							
RESPIRATORY	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Hayfever / environmental allergy							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Cystic fibrosis							
Other lung disease							
SIGHT/SMELL/	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin

SOUND							
Deafness before age 60							
Ear deformity							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Deviated septum							
Other							
SKIN	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Neurofibromatosis							
Other skin diseases							
CHROMOSOMAL ABNORMALITIES	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Turner syndrome							
Klinefelter syndrome							
Other							
URINARY	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Kidney disease							
Other							
OTHER ISSUES	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Alcoholism							
Drug abuse, misuse, or addiction							
Any other cancer not mentioned							
Any other condition not mentioned							

If you indicated any of the conditions listed above, please describe below:

Please attach a recent photograph

Consent to View Photo

I consent to have my photograph viewed by a prospective egg recipient couple. I recognize that this will be used solely to determine whether my physical appearance is comparable to that of the wife, and that this photo will not be release to the couple from Carolina Conceptions.

Donor signature

Print Name

Date