Female Patient Name: _____ Social Security#:____-____-_____

Karande & Associates, S.C. doing business as

InVia Fertility Specialists

EGG DONOR CONSENT
Description, Explanation and Informed Consent

I, _____, (the Donor) voluntarily offer my services as a donor of eggs, which will be used by a Recipient(s) in connection with Assisted Reproductive Technology (ART) procedures carried on in connection with the Oocyte (egg) Donor Program of INVIA FERTILITY SPECIALISTS.

The members InVia Fertility Specialists staff, including physicians, embryologists, nurses, procedure staff, clerical and laboratory personnel are known as the "ART team." I understand that by signing this form, I give my consent to the use, by the ART team, of those assisted reproductive technologies and donor oocyte procedures determined to be appropriate for me by the ART team in connection with my participation in the combined Assisted Reproductive Technologies and Donor Programs.

I understand that I will be treated with fertility drugs, monitored using ultrasound, tested for serum (blood) hormone concentrations and subjected to such other procedures as the members of the ART Team determine are appropriate and are subsequently consented to by me. I have also been advised and understand that eggs will be obtained from me surgically by ultrasound guided aspiration of follicles in my ovaries.

I have been informed and understand that the eggs obtained from me by the ART team will then be donated to a Recipient(s) to be used for the purpose of attempting to establish a pregnancy. I understand that the ART Team will attempt to fertilize these eggs with sperm from the Recipient's male partner or with donated sperm. I have been informed and understand that if fertilization occurs and embryonic development begins, the embryos produced will be transferred to the uterus of the female Recipient.

I understand that by signing this Consent to act as a Donor, I relinquish all claims to the eggs and to any child/children that result(s) from the use of eggs donated by me. If there are embryos created in excess of what is safe to transfer to a Recipient's uterus at a single time, then the disposition of those embryos will be determined by the Recipient(s). They may be frozen for the Recipient's/Recipients' future use, disposed of pursuant to InVia Fertility Specialists policies, donated to the Embryo Donation Program at INVIA FERTILITY SPECIALISTS, or utilized for research according to InVia Fertility Specialists Policies. I understand that the identity of the Recipient(s) shall not be disclosed to me unless I have donated eggs for use by the following known designated Recipient(s) as named below:

_____

Anonymous Donors Only: I have been informed and understand that my identity will not be disclosed to the Recipient(s) of my eggs. Likewise, I will not be given any information about the identity of the Recipient(s). I understand that in certain cases, for medical reasons, it may be necessary for a Recipient couple to seek certain medical information about my family or myself after completion of the cycle. I authorize the ART Team to contact me in the future to find this information. I understand that INVIA FERTILITY SPECIALISTS will make all reasonable efforts to maintain my anonymity.

Initials_____

DESCRIPTION OF THE DONOR EGG PROGRAM – DONOR

- **Pre-Art Evaluation**. Determination by standard fertility tests that I am a suitable candidate for ART. These tests may include, but are not limited to, blood tests, cervical cultures, ultrasound tests, specialized x-rays and/or psychological testing.
- **Fertility Drugs**. Use of fertility drugs to cause more than one egg to develop at a predictable time. "Fertility drugs" include but are not limited to clomiphene citrate, gonadotropins (i.e. Gonal-F, Follistim, Repronex, Luveris, Ovidrel, Profasi), leuprolide acetate (Lupron), and ganirelix
- **Pre-ART Medication**. Treatment with birth control pills or vaginal devices, antibiotics and/or glucocorticoids (steroids) as deemed necessary by the ART team.
- **Ovulation Monitoring**. Ultrasound examinations combined with blood tests to determine the expected time of egg maturation (progress of development) and ovulation. The ultrasound exams are performed transvaginally, with exceptions at times for abdominal scanning, as determined by the physician.
- **Egg Retrieval**. Collection of eggs from the Donor's ovary(ies) by placing a needle into the ovary through the vagina and aspirating the follicular contents using ultrasound guidance. The collection of eggs will be performed under anesthesia.
- **Post-ART Medication.** Treatment with antibiotics after the retrieval to prevent the potential for infection.

Initials_____

RISKS OF EGG DONATION/REASONS FOR ADVERSE RESULTS INCLUDE BUT ARE NOT LIMITED TO:

- **Allergic Reactions**. Irritation, redness or swelling may result from the injection/use of fertility medications.
- **Poor Ovarian Response**. Follicles containing mature eggs may not develop during the drug treatment cycle, or the response to the drugs may be inadequate and prevent the ART team from performing an egg retrieval. This will result in a cancellation of the ART process for this particular cycle.
- **Bruising**. Bruising may result from injections and blood draws.
- **Mechanical Obstructions**. Pelvic scarring, adhesions and/or technical problems may prevent the retrieval of one or more eggs.
- **Early Ovulation**. Ovulation may occur prior to the attempt to retrieve the eggs, making an egg retrieval impossible.
- **Unsuccessful Aspiration**. One or more eggs may not be obtained after attempts to suction (aspirate) the follicle(s) within the ovary(ies)
- **Psychological Stress**. A substantial amount of time is required as a participant in this program, and the psychological stress of involvement may result in anxiety, time management issues, relationship stress with significant others and disappointment.
- **Over stimulation of the ovaries**. Overstimulation (ovarian hyperstimulation) may result in temporary feelings of bloating and abdominal discomfort. Rarely, severe illness may result from overstimulation in an egg donor requiring additional medical care. Such care may include the removal of pelvic/abdominal fluid. In rare cases, hospitalization may be required.

- **Pregnancy**. A pregnancy may result from the donor participating in sexual intercourse during the cycle if adequate contraception not used. If a pregnancy does occur, it may be a multiple pregnancy (twins, triplets, etc.)
- **Adverse reaction to sedation**. During the retrieval of the eggs, sedating medications will be given to me intravenously. These medications are occasionally associated with allergic reactions. Over sedation may result, leading to respiratory difficulty. This may necessitate the administration of additional medications to reverse the effects of the sedation, or the use of CPR techniques as determined necessary by the physician or anesthesia team.
- **Injury to adjacent organs**. Egg retrieval involves placing a needle into the vagina through the vaginal wall into the ovary(ies). I understand that it is possible to cause injury to blood vessels or other structures and this may rarely result in the requirement for additional medical care. Such care may include, but is not limited to, the need for a blood transfusion or for additional surgery.
- **Oocyte Abnormalities**. The eggs retrieved may not be normal.

Initials_____

AGREEMENT AND CONSENT:

1. I hereby consent to a physical examination, including taking blood and other body fluids, as well as a test for exposure to HIV (AIDS) virus for the purpose of providing the ART team with sufficient information to determine whether I am an acceptable egg donor. I have been informed of the potential risks and consequences of egg donation, including but not limited to those listed below. I have been given ample opportunity to have all of my questions answered.

   Initials_____

2. I am voluntarily participating in the combined ART and Donor programs in hopes of producing eggs to donate to the Recipient through these technologies.

   Initials_____

3. By participating in this program, I accept the responsibilities, conditions and risks involved as set out in this document and as explained to me by members of the ART team. In addition, I consent to the techniques and procedures required to attempt assisted reproductive technologies as they have been described in this document and as the ART team has explained them to me. Specifically, I agree to the following requirements of the Donor Program:

   - To submit to any blood or cervical tests for hormone levels, infectious disease, genetic traits testing and drug screening that are required by the ART team.
   - To undergo psychological testing as required.
   - To take all medications as instructed by the ART team, including but not limited to fertility enhancing drugs, leuprolide, ganirelix, gonadotropins including human chorionic gonadotropin (hCG), birth control pills, vaginal contraceptive rings, steroids and antibiotics.
   - To keep all appointments for vaginal ultrasounds and laboratory tests that are required as a part of ovulation monitoring.
   - To abstain from intercourse or use a non-hormonal form of contraception (such as tubal ligation, condoms or a diaphragm) if I have intercourse with my partner during my ART cycle; and to notify the ART team if I engage in intercourse with a new partner(s).

- To refrain from all use of recreational drugs including but not limited to, cocaine, marijuana, heroin, ectasy, LSD, and PCP.
- To not acquire any new or expanded body piercings or tattoos during my ART cycle.
- To inform the ART team of any prescription, over the counter and/or herbal preparations I plan to use during my ART cycle BEFORE I use them.
- To postpone any non-emergency surgery or medical procedures until after my ART cycle, and to notify the ART team immediately in the event that an emergency medical procedure is required.
- To undergo egg retrieval on the specified date and time, and at the specific location, as directed by the ART team.
- I also understand and agree that these medications will require self-administration, usually by injection, and that I am responsible to take these medications precisely as directed by the ART team. I understand that the use of these medications requires close monitoring, including the use of ultrasounds and blood tests as determined by the ART team. I agree to confirm the self administration of these drugs as required and acknowledge that I have been informed that a member of the ART team is available 24 hours a day, 7 days a week, should an emergency consultation be needed for questions concerning medication dosage, administration or timing. I understand that my strict adherence to the instructions of the clinical staff is essential for the safe and effective usage of these medications.
- I acknowledge and agree that the use of fertility enhancing drugs is a dynamic aspect of medicine and that, from time to time, specific medications may be used or discontinued based on newly published scientific information. I also acknowledge that it may be necessary to introduce certain medications alone or in combination with established regimens of treatment selectively to certain groups of patients to determine their effectiveness in producing ovulation and/or pregnancy. I understand that some combinations may be used in some patients and not in others, based on known or hypothesized scientific information. I understand that a new drug or combination of drugs may be given to some patients and that others will continue to receive a standard regimen to determine the effect on pregnancy rates (randomization).
- I acknowledge that I have had the opportunity to ask questions about the use of fertility enhancing medications in general and in my case specifically. I consent to the use of fertility enhancing medications. I understand the risks, consequences, and benefits as explained to me.

Initials_____

4. The process of ultrasound-guided egg retrieval has been explained to me in detail by the ART team. I understand that I will undergo this procedure provided that my ovulatory stimulation produces adequate follicles, as determined by the ART team. I further understand all risks /adverse effects of this procedure.

Initials_____

5. I have been informed and understand that the eggs obtained from me during the egg retrieval will be donated to the Recipient to be used by the ART team for the express purpose of attempting to achieve pregnancy in the Recipient. I understand that the ART team will attempt to fertilize these eggs with sperm from the Recipient's male partner or with donated sperm. I have been informed and understand that, if fertilization occurs

and embryonic development begins, the embryos produced will be transferred to the uterus of the Recipient.

Initials_____

6. I understand and agree that by my affixing my signature to this ART and Donor Program Description, Explanation and Informed Consent, on behalf of myself, my agents, heirs, administrators, personal representatives, executor or spouse, that **I EXPRESSLY RELINQUISH ANY AND ALL CLAIMS, PRESENT OR FUTURE, TO ALL OOCYTES (EGGS) AND/OR ANY CHILD OR CHILDREN THAT MAY RESULT FROM MY PARTICIPATION IN INVIA FERTILITY SPECIALISTS ART PROGRAM.** I further understand that all eggs obtained from me, and all embryos produced through the use of my eggs, are the sole property of the Recipient(s); therefore, the disposition of any such egg(s) and/or embryo(s) will be determined solely by the Recipient(s). I understand that the identity of the Recipient(s) shall not be disclosed to me at any time.

   Initials_____

7. I acknowledge and agree that my acceptance into the ART Program and my continued participation is at the discretion of the ART team.

   Initials_____

8. I understand that if I should suffer any physical injury, experience complications or require hospitalization as a result of participation in this program, all medical facilities are available for treatment. I understand that any expenses not covered by my own health insurance will be reimbursed with proper documentation

   Initials_____

I understand that if my services have been contracted through an outside agency/facility other than INVIA FERTILITY SPECIALISTS, financial reimbursement has been arranged through them and

Item 9 is not applicable to me.

Initials_____

9. I understand that I will receive $7000.00 at the completion of the cycle, if I have followed all of the steps as instructed by the ART team. These steps include but not limited to taking all medications, coming to all ultrasound appointments, taking my hCG shot exactly when instructed, and undergoing the egg retrieval process. This compensation will be given to me at the 3 week follow-up appointment with a physician from INVIA FERTILITY SPECIALISTS. If I am matched and am cancelled at any point after starting birth control pills or the vaginal contraceptive ring, through no fault of my own, I will receive $250.00. If I am cancelled after starting the 1st injectable medications(leuprolide acetate, ganirelex, etc), through no fault of my own, I will receive $500.00, if I am cancelled after starting the 2nd injectable medications(FSH, LH), through no fault of my own, I will receive $750.00.

   Initials_____

On behalf of myself, my agents, assigns, heirs, administrators, personal representatives, executors and spouse, I release and forever discharge the ART team from all damages or causes of action, either at law or equity, which I may have or acquire or accrue to me or my spouse, agents, assigns, heirs, administrators, personal representatives or executors as a results of the egg donation process or medical care related thereto.

I hereby consent to the donation of my eggs. I understand that if I am married, my spouse must also sign this consent form.

Signature of Donor	Donor Name (print)	Date

I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risk attendant to the donation of eggs and hereby signify my agreement to my spouse's participation in the procedure.

Signature of Donor's Spouse	Spouse's Name (print)	Date

INVIA FERTILITY SPECIALISTS, by my signature indicates that the foregoing consent was read, discussed and signed in my presence.

Signature of Witness (for Donor)	Witness Name (print)	Date
Signature of Witness (for Spouse)	Witness Name (print)	Date

NOTE: If you or your partner are unable to have this consent witnessed by a staff member at INVIA FERTILITY SPECIALISTS or DO NOT FULLY UNDERSTAND THE CONSENT, please notify the ART team. We will provide you with further information and a witness. If you wish to sign the consent outside of INVIA FERTILITY SPECIALISTS, please have the consent notarized.

NOTARY PAGE ATTACHED

Notary Page

State of _____, County of _____. I, the undersigned, a Notary Public in and for the said County in the

State aforesaid; DO HEREBY CERTIFY that _____
(Egg Donor/ Spouse)

personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this _____day of_____, 20_____,

Commission expires on: _____, 20_____.

_____
Notary Public

(Notary Seal)