Female Patient Name: _____ Social Security # _____

Partner's Name: _____ Social Security # _____

Karande & Associates, S.C. doing business as

InVia Fertility Specialists

DONOR OOCYTE PROGRAM—RECIPIENT
Description, Explanation and Informed Consent

We, _____, and _____, in connections with our participation in The Assisted Reproductive Technologies (A.R.T.) Program. INVIA FERTILITY SPECIALISTS have reviewed and executed the form captioned "Assisted Reproductive Technologies Program Description".

As part of our participation in the A.R.T. program, we hereby authorize the A.R.T. Team of INVIA FERTILITY SPECIALISTS in connection with the A.R.T. procedures and treatments, to use eggs donated by a woman (hereinafter the Donor) other than the female patient.

We have been informed that the egg donor will be treated with fertility drugs, monitored with ultrasound equipment and will have eggs surgically removed by ultrasound-guided aspirations. We have also been informed that the A.R.T. Team will attempt to fertilize some or all of such eggs with sperm collected from the Male partner and/or Donor sperm previously chosen.

It is our understanding that the donor eggs will be used within 24-36 hours after collection and that the use of such freshly collected eggs creates a remote possibility of transmission of infectious disease, including but not limited to HIV (AIDS), to any child born as a result of the procedures as well as to the female patient. We have been informed that the egg Donor will be screened for infectious diseases prior to egg donation but that such screening does not completely eliminate the risk of infectious disease transmission.

We have been advised that if fertilization occurs and embryo development takes place, the embryo(s) will be transferred to the uterus of the Female patient. We have also been informed and understand:

1. That transfer of one or more embryos may not result in the Recipient's pregnancy.
2. That if the Recipient pregnancy does result from an embryo transfer that the pregnancy may not go to full term.
3. That any pregnancy of the Recipient includes possibilities of complications during childbirth.
4. That any child unborn as a result of the pregnancy may be abnormal or a child may be born with undesirable hereditary tendencies; and
5. That there may be other adverse consequences to the Recipient(s) and/or the child.

We also understand that other risks, complications, or side effects may result from the use of the Donor's eggs in connection with Assisted Reproductive Technologies. We have been given the opportunity to ask questions about the procedures, the methods being used and the risks and hazards involved and we believe that we have sufficient information to give this informed consent. We have also discussed with the A.R.T. Team alternative treatments and it is our decision to accept the risks described above.

We hereby rely upon the discretion of the A.R.T. Team in the selection of qualified egg donors. We acknowledge and agree that the identity of the Donor will **not** be revealed to us unless we make use of designated donor as listed here _____. We understand and agree that all of the Oocytes from the Donor will be reserved for our use unless we have specifically indicated otherwise on the Acknowledgement of Donor Oocyte Utilization Form.

We hereby agree that any child born as a result of our participation in the Program is a child conceived by our acts and hereby acknowledged that such child is our legitimate child with all the the rights and privileges accompanying such status.

We hereby agree and understand that the Donor has exposed herself to the potential risk and/or harm by taking the injectable fertility drugs. We therefore agree that because of this said risk, we shall compensate the Donor in the amount of $7,000.00 in Illinois. We also agree that because of this said risk, once the Donor starts the injectable medications, if for any reason should the cycle be cancelled before retrieval, at no fault of the Donor, we will reimburse the donor per agreed upon fee schedule listed in Recipient contract. Should the cycle be cancelled after retrieval, at no fault of the Donor, we will still reimburse the Donor the full compensation fee of $7,000.00 in Illinois.

We have received a written description of the Ooctye Donor Program and understand the financial responsibility for our involvement in the program as a Recipient couple. We understand that by entering this program, we are financially responsible for the costs incurred by ourselves as well as those of the Donor. The only exception to the above fee compensation would be in the event the Recipient couple provides their own Donor.

To ensure against risk/harm to the Donor, we agree to purchase the mandatory Donor Insurance coverage as required by INVIA FERTILITY SPECIALISTS for the amount of $615.00. We understand that this insurance policy will provide coverage for any complications associated with the ovarian stimulation and/or oocyte retrieval processes including transportation to and from medical visits. We also understand that the only exceptions to purchasing this insurance policy would be that an insurance policy has already been purchased through an outside agency or that written proof of medical coverage from the Recipient couple's health insurance company is received by INVIA FERTILITY SPECIALISTS covering the donor should medical complications arise. We understand that even after purchasing a Donor Insurance policy **all financial responsibility** for all costs that may arise from any complications associated with the ovarian stimulation and/or ooctye retrieval processes including transportation to and from medical visits remain our responsibility if not covered by said insurance policy. We have been informed and understand that the risks inherent in any A.R.T. procedure are very small. However, as a result of our agreement to participate in the Oocyte Donor Program, we accept this risk, understanding that the Donor is voluntarily entering this program in an attempt to assist us in achieving a pregnancy.

All of our questions regarding INVIA FERTILITY SPECIALISTS Donor Oocyte Program Agreement—Recipient have been answered. Each of us has had the opportunity to read the consent, have had the content fully reviewed with us in our presence, and acknowledges receipt of a copy of this consent. By signing below, we agree to this agreement in its entirety.

_____	_____	_____
Date	Signature of Female Patient	Female Name – Print
_____	_____	_____
Date	Signature of Spouse (If Applicable)	Spouse Name – Print

As one of the members of INVIA FERTILITY SPECIALISTS, by my signature indicate that the foregoing consent was read, discussed, and signed in my presence.

_____	_____	_____
Date	Signature of Witness (Female Patient)	Witness Name – Print
_____	_____	_____
Date	Signature of Witness (Spouse)	Witness Name – Print

NOTE: If you or your partner are unable to have this consent witnessed by a staff member at INVIA FERTILITY SPECIALISTS or FULLY UNDERSTAND THE CONSENT, please notify the INVIA FERTILITY SPECIALISTS medical staff. 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.

_____

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

State aforesaid; DO HEREBY CERTIFY that _____
(Female Patient / Patner)

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)
