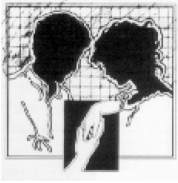


Center for Fertility and In Vitro Fertilization

Loma Linda University Health Care
11370 Anderson Street - Suite 3950, Loma Linda, California 92354
Phone (909) 558-2851 Fax (909) 558-2450 Web: www.llu.edu/lluhc/fertility

Thank you for your interest in our Egg Donation Program. Our Center is currently seeking women 21-32 years old who are interested in donating oocytes (eggs) to infertile women. Women from all ethnic backgrounds are encouraged to apply. We prefer egg donors to have had at least one child.

Egg donors are either anonymous or known by the recipient. Donors provided by our Center remain anonymous to the recipient. A donor known by the recipient is usually one the recipient has located without our assistance.

Being an egg donor involves several visits to our office, a visit with a clinical psychologist, blood draws, ultrasound examinations of your ovaries, daily injections and ultrasound-guided egg retrieval. If an egg donor is married or in a sexually intimate relationship, the partner is also screened for sexually transmitted diseases.

Egg donors provided by the Center receive $5,000. at their post operative physical exam two weeks after the egg retrieval in compensation for their time. We are required to report compensation paid to donors to the IRS. Donors receiving compensation are required to claim the income (Form 1099-M) with their annual tax return.

The enclosed material describes the program in greater detail. Please complete the screening questionnaire and return it in the stamped self-addressed envelope (enclosed). The consent forms are provided for you to review. Please do <u>not</u> complete the consent form at this time. Should you become an egg donor, a physician will review the contents of the consent form with you before obtaining your signature.

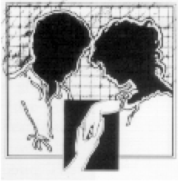
After reviewing your completed questionnaire our Program Coordinator will contact you and possibly make an appointment for an initial consultation.

Again, thank you for your willingness to help another couple have a child. We hope you understand the importance of your participation in the process and the profound appreciation for your help which is expressed by recipients of egg donation.

Sincerely,

Johannah Corselli, Ph.D., H.C.L.D.
Director, Egg Donation Program

phlebotomy\c$/donor-phlebot\edonor.ltr 10/25/04
Revised 3/24/05



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OVERVIEW OF THE EGG DONOR SCREENING PROCESS

EGG DONOR CANDIDATES

Candidates for egg donation are women between the ages of 21 and 32 who are healthy and whose parents and grandparents are healthy, free of cancer, heart disease, high blood pressure, high cholesterol and diabetes. Previous fertility in the egg donor is preferred. Employees of the Center for Fertility may not serve as egg donors.

THE SCREENING PROCESS

Screening consists of approximately three to five appointments each requiring an hour or more of time. There are consultations with the Program Coordinator, Clinical Psychologist and Physician. A physical exam is provided, cultures and blood tests are performed. The spouse or intimate partner of an egg donor will also be asked to give blood for testing to rule out sexually transmitted disease. The medical care received is free of charge.

ACCEPTANCE OF EGG DONORS

Applications are first reviewed by our program coordinator, program director and medical director. Applicants with histories compatible with safe and successful egg donation are asked to come in for a clinical interview. In the clinical interview, the family medical and genetic histories are reviewed and your questions and concerns regarding the process can be addressed. We would appreciate it if you could bring a picture of yourself and any children you may have to retain in our files for reference. After the clinical interview you may be accepted as an egg donor on a preliminary basis. It is extremely important to be absolutely honest in completing your application and in answering questions. Any information obtained is highly confidential. Your medical records pertaining to egg donation are located in a high security setting separate from other medical records

Couples requesting egg donation will be allowed to review a summary of your application for physical characteristics (eye color, hair color, height, weight), medical and genetic history. Information which identifies you will have been removed from the application. Should a couple select you, we will call and ask you to make an appointment with our clinical psychologist. After receiving clearance from the psychologist, appointments will be scheduled for lab work and a physical examination. If the evaluation indicates that undergoing egg donation would be safe for you and factors are favorable for an outcome, arrangements will be made to synchronize the donor and recipient cycles. Birth control pills are commonly prescribed to first gain control of the menstrual cycle.

THE EGG DONATION CYCLE

An approximate date for the egg retrieval will be established based primarily on a time frame acceptable for both the egg donor and recipient couple. In preparation for ovulation induction, the donor will be given injection technique instructions. A friend or spouse may also be trained to give the injections. Lupron (leuprolide acetate) injections will be taken subcutaneously in the thigh area daily for approximately 25 days. Lupron will be taken to suppress release of hormones from the pituitary gland that stimulate the ovaries. The donor will inject a second medication subcutaneously (follicle stimulating hormone, FSH) for 8-12 of the 25 days. FSH is required to stimulate follicle maturation in the ovary. Variations in the medications prescribed will occur depending on what the physician believes is best for you.

The last two weeks of the egg donation cycle when FSH is injected is time intensive. Donors are asked to be at the Center at about 7:30 am nearly every morning in the second week (the week of egg retrieval) for a blood test and ultrasound examination of the ovaries. When the physician determines that the eggs are ready to recover, a third injection is taken (human chorionic gonadotropin, hCG). Egg retrieval will be scheduled in the Fertility Center for about 34- 36 hours after the hCG injection. The egg retrieval will take place in the morning and last about an hour. Most women will need about one hour for recuperation in the Fertility Center after egg retrieval. Egg donors must make arrangements for someone else to drive home after the egg retrieval as driving is not allowed.

Payment for your time and inconvenience in the amount of $5,000. will be provided at your post procedure examination two weeks after the egg retrieval. Unfortunately, no compensation is available for cycles which fail to progress to egg retrieval.

WHAT IS NEXT?

If you are still interested in being an egg donor after reading this information, please fill out the screening forms and mail it back to the Center. Your application must be completed in full! After reviewing your application, you will be contacted to inform you of your suitability for egg donation. If you have not been contacted within one month of submitting your application, please call our office at (909) 558-2851 to confirm that your application has been received and is under review.

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11/08/2001jc

Revised 11/01/04
Revised 3/24/05

INSTRUCTIONS
(DONOR)

This screening form is very important to obtain information about you and your family. The information is essential for our evaluation of you as a potential egg donor. The following are guidelines to help you to fill out this form.

1. Please fill in all banks completely. Write "NA" in blanks that are not applicable. Write "UNK" in blanks where you do not know the answer.

2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships such as "first cousin through my mother's sister."

3. Please provide information on all the relatives requested. You do not need to list names.

If you have any questions, please note them and ask them at the time of the next appointment or contact one of the Fertility Center nurses at (909) 558-2851.

Thank you for your cooperation.

I.D.#___________

EGG DONOR SCREENING FORM

1. Date: __________ SS#: ________________________Driver's License #______________

2. Name: ________________________________Date of Birth____________ Age: _______

3. Current Address: ____

4. Home phone number:___________________Cell phone:___________________________

5. Employer:____

6. Employer Phone number:____

7. Occupation:_______________________ Education (Years completed):________________

8. Do you have health insurance?________ If yes, give provider:________________________

9. Where and when may we contact you:____

10. ABO (Blood) Type: ___________________________ Rh: ________________________

11. Height: _____ Weight: _____ Eye Color: __________Hair Color_______________________

12. Ethnic origin of your mother's family: ____

13. Ethnic origin of your father's family: ____

14. Are you adopted?: ____

15. Do you grant permission to show your picture to the recipient couple? Yes_____ No_____

****

YOU WILL BE REQUIRED TO SHOW YOUR DRIVER'S LICENSE OR A VALID FORM OF PICTURE IDENTIFICATION WHEN YOU COME IN FOR AN INTERVIEW. IF YOU HAVE INSURANCE, PLEASE BRING YOUR INSURANCE INFORMATION ALSO.

I.D.#____________

GENERAL INFORMATION

Please describe your interests and your hobbies:

Please describe yourself and your personality traits:

Please describe why you are interested in becoming an egg donor:

I.D.____________

MEDICAL HISTORY

1. OPERATIONS

Year	Type of Operation	City, State
_______	________________________________	________________
_______	________________________________	________________
_______	________________________________	________________
_______	________________________________	________________
_______	________________________________	________________

2. HOSPITALIZATION OTHER THAN SURGERY

Year	Reason	City, State
______________	________________	____________
______________	________________	____________
______________	________________	____________
______________	________________	____________

3. Have you ever had any serious injuries? ____

____

Any broken bones? ___________

If yes, please describe: ____

____

4. Have you ever had any serious illnesses? ____

If yes, please describe and give age of diagnosis:________________________________

____

____

5. Are you presently under a physician's care? ________________________

If yes, please describe: ____

____

6. Current medications or treatments (include over the counter medications).

Medication	How Often	Reason
______________	_______________	____________
______________	_______________	____________
______________	_______________	____________
______________	_______________	____________

7. Do you wear glasses or contact lenses? ____

8. Alcohol use? ______________________ How much? _____________________

9. Do you smoke? ____________________ How much? _____________________

If no, have you smoked previously?: ________ How many years? ______________

10. Usual weight: __________lbs Recent change? _____________________________

11. Allergies (medicines, food, pollens)? ____

12. Are you at risk for human autoimmune deficiency syndrome (AIDS)?

_____Yes ______No _____Don't Know

13. Past or present use of intravenous drugs? ________yes__________no _________don't know

14. Do you have ear and or any other body piercing? Yes No

If yes, when did you have the last piercing done? ________________________________

15. Do you have any tattoos? _______yes ________no

If yes, when did you have the last one done? ________________________________

16. Please indicate if you have ever had any of the following:

	Yes	No	Unsure
Gonorrhea	______	______	_______
Syphilis	______	______	_______
Herpes	______	______	_______
Hepatitis B	______	______	_______
Hepatitis C	______	______	_______
Blood transfusion	______	______	_______
Liver disease	______	______	_______
Injuries	______	______	_______
Prolonged Fever	______	______	_______
Kidney disease	______	______	_______
Allergies	______	_______	_______
AIDS	______	______	_______
HIV Positive	______	_______	_______
Chlamydia	______	_______	______
Psychiatric disorders	______	_______	______
Measles	______	_______	_______
Diabetes	______	______	_______
Tuberculosis	______	______	_______
Fever above 101° or greater in the past 3 months	_____________		_______

Explain any "yes" answers: ____

____

____

17. Menstrual History:

Last menstrual period ________________

Usual cycle length ________________

Are cycles regular? ________________

Age at first period ________________

Duration of flow ________________

Pain with periods? ________________

18. Contraceptive History:

Method(s) Used	Year(s) used
________________	________________
________________	________________
________________	________________
________________	________________

Current contraception? ________________________

19. Pregnancy History:

Total number of pregnancies ________________ Dates ________________

Number of living children ________________ Ages ________________

Number of miscarriages ________________ Dates ________________

Abortions/Gestation Age ________________ Dates ________________

Delivery Date	Gestational Age	Place	Complications
____________	____________	__________	__________
____________	____________	__________	__________
____________	____________	__________	__________
____________	____________	__________	__________

20. Sexual History:

Are you currently sexually active? ___________________

If "yes", are you currently in a monogamous relationship?: ____________________

Total # of partners? ______________ #Partners in last 6 months? ______________

How long with the current partner? _______________________

Are you homosexual or have you had any homosexual or bisexual relationships?

______________Yes ______________No

20. Place a check (✓) in front of any of the following that are a problem for you.

____ Rashes, color change
____ Itching
____ Warts, moles
____ Eczema, lumps, hives
____ Very dry skin
____ Excessive sweating
____ Bleeding or bruising from minor injury
____ Anemia
____ Lymph node or gland swelling
____ Ear trouble, infection
____ Hearing loss, ringing in ears
____ Eye problems
____ Nose bleeds
____ Stuffy nose, sinus trouble
____ Hay fever
____ Sore throats
____ Hoarseness
____ Dental or gum problems
____ Breast lumps
____ Shortness of breath
____ Cough, chest colds
____ Bringing up sputum with blood
____ Wheezing, asthma
____ Diabetes

____ Frequent urinating
____ Waking to urinate (#/night)
____ Genital sores or discharge
____ Trouble swallowing
____ Poor appetite
___ Gas, Cramps, Pains
___ Heartburn, Indigestion
____ Nausea, Vomiting
____ Constipation, Diarrhea
____ Blood in stool or black stool
____ Yellow (jaundice), Hepatitis
____ Hemorrhoids
____ Hernia
____ Gall bladder problems
____ Pains in joints, arthritis
____ Swollen joints
____ Back pain, neck pain
____ Enlarged or painful breasts
____ Discharge from nipples
____ Head injury
____ Headaches
____ Dizziness, fainting
____ Convulsions, seizures
____ Minor injury

____ Chest pain, pleurisy
___ Shaking, tremor
___ TB, or exposure to TB
___ Weakness, paralysis
___ Fevers, sweats, chills
Numbness, tingling
___ Pneumonia
___ Difficulty walking, coordination
___ Chest pain, tightness pressure
___ Poor sleeping
___ Fast or irregular heartbeat
___ Nervousness, tension
___ Trouble breathing lying down
___ Trouble thinking, remembering
___ Waking short of breath
___ Sexual problems
___ Swelling of feet or ankles
___ Murmurs or rheumatic fever
___ Previous heart trouble
___ Poor circulation, varicose veins
___ High blood pressure
___ Blood clots
___ Cancer
___ Goiter, thyroid problems

Explain any "Yes" answers: ____

____

I.D.#___________

GENETIC HISTORY

1. ARE THERE ANY KNOWN GENETIC CONDITIONS OR BIRTH DEFECTS IN YOUR FAMILY?

_______No ______ Yes If yes, please explain: ___________________________________

____

2. DO YOU HAVE OR HAVE YOU EVER HAD ANY BIRTH DEFECTS? (E.G., HEART DEFECTS, CLEFT LIP OR PALATE, CLUB FEET)?

_______No ______ Yes If yes, please explain: ____________________________________

____

3. ARE YOU OF JEWISH ANCESTRY? ________Yes ________No _______ Unknown

4. ARE YOU OF BLACK ANCESTRY? ________Yes ________No ________Unknown

5. ARE YOU OF MEDITERRANEAN
GREEK or ITALIAN/ANCESTRY? _______Yes ________No ______Unknown

6. HAVE YOU EVER BEEN TESTED FOR ANY GENETIC DISEASE SUCH AS:

Tay-Sachs disease (if of Ashkenazi Jewish ancestry):

______carrier ______not carrier _______unknown

Sickle cell disease (if black ancestry):

______carrier ______not carrier _______unknown

Thalassemia (Italian, Greek, or Oriental ancestry):

______carrier ______not carrier _______unknown

Cystic fibrosis

______ carrier ______not carrier _______unknown

I.D.#___________

GENETIC AND MEDICAL HISTORY

CHILDREN (EGG DONOR)

1. Your children, LIVING:

	Sex	Health Problems/Mental Retardation	Age Diagnosed
1.			
2.			
3.			

2. Your children , DECEASED:

	Sex	Age at Death	Cause of Death	Age Diagnosed	Health Problems/ Mental Retardation
1.					
2.					
3.					

GENETIC AND MEDICAL HISTORY
EGG DONOR'S SIBLINGS AND HALF-SIBLINGS

1. YOUR BROTHERS AND SISTERS, LIVING:

	Sex	Age	Health Problem/Mental Retardation	Age Diagnosed
1.				
2.				
3.				

2. YOUR BROTHERS AND SISTERS, DECEASED (INCLUDES STILLBORNS, INFANT DEATHS, CHILDHOOD DEATHS):

	Sex	Age at death	Cause of Death	Age Diagnosed	Health Problems/ Mental Retardation
1.					
2.					
3.					

I.D.#____________

GENETIC AND MEDICAL HISTORY

FATHER'S FAMILY

1. GRANDFATHER (YOUR FATHER'S FATHER): _______Living _______Dead

   Age (or age at death) _______ If dead, cause of death: ______________________________

   Health Problems/Mental Retardation and Age Diagnosed: ____________________________

   ____

2. GRANDMOTHER (YOUR FATHER'S MOTHER): ______Living ______Dead

   Age (or age at death) ______ If dead, cause of death: ______________________________

   Health Problems/Mental Retardation and Age Diagnosed: ____________________________

   ____

3. AUNTS AND UNCLES (YOUR FATHER'S BROTHER AND SISTERS), LIVING:

	Sex	Age	Health Problems	Age Diagnosed
1.				
2.				
3.				
4.				

4. AUNTS AND UNCLES (YOUR FATHER'S BROTHERS AND SISTERS),: DECEASED (INCLUDE STILLBORNS, INFANTS DEATHS, AND CHILDHOOD DEATHS):

	Sex	Age	Cause of Death	Age Diagnosed
1.				
2.				
3.				
4.				

5. **FATHER:** ______Living _______Dead

   Age (or age at death) _____ If dead, cause of death: ________________________________

   Health Problem/Mental Retardation and Age Diagnosed: _____________________________

   ____

I.D.#___________

GENETIC AND MEDICAL HISTORY

MOTHER'S FAMILY

1. GRANDFATHER (YOUR MOTHER'S FATHER): _______Living _______Dead

   Age (or age at death): _______ If dead, cause of death: _______________________________

   Health Problems/Mental Retardation and Age Diagnosed: _____________________________

   ____

2. GRANDMOTHER (YOUR MOTHER'S MOTHER): _______Living_______Dead

   Age (or age at death): _______ If dead, cause of death: _______________________________

   Health Problems/Mental Retardation and Age Diagnosed: _____________________________

   ____

3. AUNTS AND UNCLES (YOUR MOTHER'S BROTHERS AND SISTERS), LIVING:

   Sex Age Health Problems/Mental Retardation Age Diagnosed

   1. ____
   2. ____
   3. ____
   4. ____

4. AUNTS AND UNCLES (YOUR MOTHER'S BROTHERS AND SISTERS), DECEASED (INCLUDES STILLBORNS, INFANT DEATHS, AND CHILDHOOD DEATHS):

   Sex Age at Death Cause of Death Age Diagnosed

   1. ____
   2. ____
   3. ____
   4. ____

5. MOTHER: _______Living ________Dead

   Did your mother have more than one miscarriage? _____Yes _________No __________ Don't Know

   Age (or age at death): _______ If dead, cause of death: _____________________________

   Health Problems and Age Diagnosed: ____

I.D.#_________

MEDICAL AND GENETIC HISTORY
(SPECIFIC CONDITIONS)

PLEASE INDICATE WITH A CHECK MARK (✓) WHETHER YOU AND/OR YOUR RELATIVE HAVE HAD ANY OF THE FOLLOWING:

	Yes	No	If Yes* Yourself	Relatives*
1. Seizure Disorder	____	____	____	____
2. Muscular Dystrophy	____	____	____	____
3. Schizophrenia/Manic Depressive Disorder	____	____	____	____
4. Serious Birth Defects	____	____	____	____
5. Cleft Lip and/or Cleft Palate	____	____	____	____
6. Huntington's Disease	____	____	____	____
7. "Open Spine" or "Water on the Brain"	____	____	____	____
8. Congenital Heart Defects	____	____	____	____
9. Tuberous Sclerosis	____	____	____	____
10. Diabetes Mellitus	____	____	____	____
11. Neurofibromatosis	____	____	____	____
12. More Than Five Coffee-Colored Spots on the Skin (size of a Quarter or Larger) or numerous lumps under the skin	____	____	____	____
13. Early Death of Heart Attack (<50yo)	____	____	____	____
14. Cystic Fibrosis	____	____	____	____
15. Severe Bleeding Tendency	____	____	____	____
16. Congenital Hip Dislocation	____	____	____	____
17. Clubfoot	____	____	____	____
18. Hypospadias	____	____	____	____
19. Albinism	____	____	____	____
20. Hemophilia	____	____	____	____
21. High Blood Cholesterol	____	____	____	____
22. Asthma	____	____	____	____
23. High Blood Pressure	____	____	____	____
24. Rheumatoid Arthritis	____	____	____	____
25. Polycystic Kidney Disease	____	____	____	____
26. Down's Syndrome	____	____	____	____
27. Mental Retardation	____	____	____	____
28. Premature Senility (Before 60)	____	____	____	____
29. Deafness (Before 60)	____	____	____	____
30. Blindness in both eyes (Before 60)	____	____	____	____
31. Cataracts (Before 60)	____	____	____	____
32. Two or more Miscarriages or Stillborn	____	____	____	____
33. The same cancer in more than one family member	____	____	____	____
34. Alcohol or Drug Abuse	____	____	____	____

IF YES TO ANY OF THESE, PLEASE ANSWER BELOW:

QUESTION #	SPECIFIC RELATION	SPECIFIC CONDITION	AGE AFFECTED
________	__________	___________	___________
________	__________	___________	___________
________	__________	___________	___________

* = Your Parents, Siblings, Children, Aunts, Uncles, Grandparents

EGG DONOR GENETIC AND MEDICAL HISTORY CERTIFICATION

I certify that the information I have provided is to the best of my knowledge a true and complete account of my medical, genetic, and family medical history, under penalty of perjury.

____________________________________ _______________________

Egg Donor (Applicant) Date

____________________________________ _______________________

Witness Date

donor-phlebotomy\DONHISTO
11/16/2001
Revised 10/28/04