

MODEL FORM

[Program's SART Name and Number] *

INFORMED CONSENT FOR EGG DONORS

You are agreeing to undergo a cycle of egg donation at [program's SART name]. Do not sign this document if you have not received all of the information listed below or have not met with your physician to discuss the information. Do not allow the donation cycle to begin until after you have given your consent by signing this document.

- a. The **SCREENING PROCESS** required at [program's SART name], including information about the following:
 1. What information you are required to provide about your personal and family history, including any verifying information
 2. Medical testing and procedures, including pre- and post-test counseling for any genetic testing
 3. Psychological screening
 4. How you can find out about your screening results, and what counseling resources are available to you if you are disqualified by any screening test or procedure
- b. A **DESCRIPTION** of the **PROCEDURES** for egg donation
- c. The **RISKS** of egg donation, including information about the risks of the following:
 1. Any **DRUGS** that will be prescribed to you
 2. **OVARIAN HYPERSTIMULATION** – In discussing the risks of ovarian hyperstimulation, your physician should have given you information about the following:
 - i. The **SYMPTOMS** of ovarian hyperstimulation
 - ii. The **CONSEQUENCES** of ovarian hyperstimulation

* The Society for Assisted Reproductive Technology (SART) is an affiliate society of the American Society for Reproductive Medicine. If your program is a current SART member, you can obtain additional information about the program from SART (website: <http://www.sart.org>). If your program is not a current SART member, it does not have a SART number and should not use or be identified by any other program's SART name or number.

- iii. Your **CHANCES** of developing ovarian hyperstimulation from taking drugs to induce ovulation
 - iv. Your physician should have discussed with you the **NUMBER OF EGGS** the program plans to produce by stimulating your ovaries with drugs. Your physician also should have explained how many eggs are thought to be safe to plan to produce during a single donation cycle, and that you are more likely to develop ovarian hyperstimulation if the program plans to produce more than this number of eggs.
3. The process of **REMOVING EGGS** from your body
 4. Any other problems that might happen because of your egg donation, including any potential **LONG-TERM PROBLEMS** that might not occur until later in your life
- d. Any **PAIN** or **DISCOMFORT** that you may have from the drugs or the procedures and how it may restrict your work or other activities
 - e. **PSYCHOSOCIAL** and **EMOTIONAL SUPPORT**, including **PSYCHOLOGICAL COUNSELING**, to help you deal with the psychosocial and emotional aspects of egg donation, including information about the following:
 1. The **AMOUNT OF TIME** involved in the donation process
 2. The possible **RESTRICTIONS** on your work and activities due to the drugs or the procedures
 3. How the donation process may affect your family or partner
 4. The support and counseling resources provided by **[program's SART name]** and the process and costs to get those services
 5. A list of counseling resources that are not affiliated with **[program's SART name]**
 - f. How **WELL-ESTABLISHED** each procedure is in the field, including whether it is:
 1. Generally accepted within the relevant medical community, or
 2. New and innovative and not generally accepted within the relevant medical community

- g. How much **EXPERIENCE** [program's **SART name**] has with each procedure, including the level of training of the professional staff

- h. Your **FINANCIAL OBLIGATIONS**, including information about the following:
 - 1. **WHAT COSTS ARE and ARE NOT COVERED** by [program's **SART name**] and/or its **INSURANCE**
 - 2. Any **COSTS** associated with your egg donation that you may be **RESPONSIBLE FOR**
 - 3. Who is responsible for the cost of **MEDICAL COMPLICATIONS** associated with your egg donation, including expenses related to any potential **LONG-TERM PROBLEMS** that might not occur until later in your life
 - 4. Whether you have any potential financial responsibility for certain medical problems that the resulting **OFFSPRING** might develop later in life
 - 5. Reporting your compensation as **TAXABLE INCOME**

- i. **COMPENSATION** for your time and expenses, including information about the following:
 - 1. The amount of compensation
 - 2. When you should expect to be paid
 - 3. [Program's **SART name**]'s policy on **PARTIAL COMPENSATION** if the egg donation cycle is cancelled before any eggs are removed from your body
 - 4. **FULL PAYMENT** after eggs are removed from your body regardless of the number or quality of the eggs

- j. [Program's **SART name**]'s policy on your **RIGHT TO WITHDRAW CONSENT**

- k. The **USES** of your donated eggs, including information about the following:
 - 1. All possible ways your eggs may be used
 - 2. Whether you may object to or restrict how your eggs can be used
 - 3. Whether you may find out about how your eggs were used, including whether you were matched to two or more recipients

4. What happens to any unused eggs or embryos created from your eggs
- l. Whether you may find out about the **OUTCOMES** of your egg donation, such as whether your donation resulted in a pregnancy or live birth
- m. Your physician should have explained that you should not assume that you will have any **PARENTAL RIGHTS AND RESPONSIBILITIES** to any resulting offspring, although state laws on these issues remain unsettled.
- n. The risks involved with **MULTIPLE EGG DONATIONS**, and whether **[Program's SART name]** has a policy on the maximum number of times that you may donate in your lifetime
- o. The **CONFIDENTIALITY** of your egg donation and your medical record, including information about the following:
 1. How **[program's SART name]** maintains confidentiality
 2. What **[Program's SART name]**'s policy is on using or disclosing information about you to others, including the recipients, any resulting offspring, or the public through advertisements or Internet postings
- p. Whether and how **[Program's SART name]** will contact you in the future

CONFIDENTIALITY – Except as required by law, your physician and **[program's SART name]** will not reveal any information about you or your egg donation without your consent, except that they may use specific medical details in professional publications as long as personal information about you is not disclosed. Statistics concerning your egg donation (without your name or other personal information) will be included in information that **[program's SART name]** provides to the Society for Assisted Reproductive Technology and the federal Centers for Disease Control and Prevention. Any other use of information about you or your egg donation would require your specific written consent.

RESEARCH – Your physician may use some of your blood or some tissues that would otherwise be discarded (such as follicular fluid, immature eggs, unfertilized eggs, abnormally fertilized eggs or follicular cells) for research or teaching purposes. Before using the blood or tissue for research or teaching, any identifying information about you will be removed.

[nth (e.g., first, second, etc.)] CYCLE OF EGG DONATION

I have read this entire consent form and have had the chance to ask any questions I might have about my egg donation. My consent to egg donation is purely voluntary. I understand that my consent applies to only one cycle of egg donation and that I may withdraw my consent at any time before eggs are removed from my body. I have received a copy of this form.

Egg Donor:

_____ Date: _____
(signature)

(print name)

PHYSICIAN CERTIFICATION: I hereby certify that before the cycle of egg donation began, and before the egg donor signed this document,

- (i) I or the staff at this program have provided the egg donor with information about the nature, purpose, benefits, risks of, and alternatives to, the proposed cycle of egg donation; and
- (ii) I have met with the egg donor to discuss the information, have given the egg donor an opportunity to ask any questions, and have fully answered such questions.

I believe that the egg donor fully understands what I have explained and answered and has consented to undergo the proposed cycle of egg donation.

Physician Responsible for the Egg Donor's Care:

_____ Date: _____
(signature)

(print name)