



We are pleased that you have expressed an interest to participate in the Oocyte Donation Program at the NYU Fertility Center - NYU Langone Medical Center (NYUFC). Due to disease, ovarian failure or age, many women are infertile because they are unable to produce healthy eggs (also called oocytes). However, with your help, these women will have a chance to have a baby. This packet will inform you about our Program's screening procedures and will provide us with necessary information to evaluate your potential as an Oocyte Donor.

Donor Screening and Selection

Our screening procedures are mandated by the Food and Drug Administration (FDA) and the New York State Department of Health, which has licensed our Oocyte Donation Program:

- **Genetic Screening** will identify whether you are a carrier of genetically transmitted diseases such as cystic fibrosis, sickle cell anemia and Tay-Sachs disease. A karyotype, a blood test that checks your chromosomes, will also be performed. Appointments for these screening tests and an interview with an NYU genetics counselor can be scheduled on Wednesdays from 1:00 – 4:00 pm.
- **Psychological screening and counseling** ensures that you understand the emotional and psychological aspects of the donation procedure. Two visits are necessary, each 90 minutes in length. Appointments with our psychologists can be scheduled Monday through Friday from 9:00am – 4:00pm.
- **Medical screening** procedures will assess your general health status. The procedures involve a physical exam and a gynecologic exam by an NYUFC physician and blood tests for communicable and sexually transmitted diseases. Our goal is to determine that you are physically able to undergo the donation procedures. The disease testing will be repeated later in the donation process as required by the FDA. Appointments for an exam and testing are available throughout the week during our office hours.
- **Drug screening** is performed as part of the application process to test for substance abuse.

Upon successful completion of each of these screening procedures, a donor will be matched to an Oocyte Recipient(s). Once matched, the next stage of the donation process will begin.

An Introduction to the Oocyte Donation Procedure

Hormone stimulation

Under normal conditions, a woman's ovary develops and releases one egg each month. Egg development is regulated by hormones secreted by the pituitary gland. In an egg donation cycle we will temporarily slow down your pituitary gland using Leuprolide Acetate (Lupron Depot). This medication is given as a single injection prior to your period. After your period begins, daily injections of Follicle Stimulating Hormone (FSH) will stimulate the development of several eggs in each of your ovaries. We will teach you how to inject yourself with FSH. The FSH injections will continue for approximately 10 days. NYUFC will provide you with all the medications that you will need.

Monitoring the Treatment Cycle

NYUFC physicians will monitor how your eggs are developing in response to the FSH injections using ultrasound examinations and blood tests. These tests are conducted early in the morning (7:00 – 9:00 am) every 2-3 days for approximately 14 days. When your eggs have matured appropriately, a single injection of another hormone, human chorionic gonadotropin (hCG), is given to trigger the final ripening of your eggs.

Egg Retrieval Procedure

Egg retrieval takes place approximately 35 hours after the hCG injection. This is a 20 minute procedure. Although this procedure will not require anesthesia, you will be administered a strong sedative by an NYU anesthesiologist who will care for you and keep you comfortable. We use an ultrasound probe in your vagina to visualize the follicles, the normal fluid filled cysts that contain your eggs in your ovaries. A thin needle is then passed through the wall of your vagina to puncture the follicles and draw out the fluid and the eggs. Following the retrieval you will be transferred to a recovery room. You should be released after an hour. We require that you have an adult escort to accompany you home.

Time Commitment

The screening procedures (medical and gynecologic exams, psychological and genetic consultations) will all take place weekdays during NYUFC office hours. After you have successfully completed the screening procedures, egg donation can be accomplished in six to eight weeks. A visit is required for a blood test on or before day 21 of your menstrual cycle to determine ovulation. Your medication protocol will begin with the Lupron Depot® injection. Approximately one week after the Lupron injection, your period will begin. Your next visit will be three days after you get your period. For the next eight to fourteen days, you will need to plan for early morning visits to NYU for blood tests and ultrasound examinations. These visits last 15 to 30 minutes and can be scheduled between 7:00 - 9:00 am, 7 days a week by the Donor Coordinator or Donor Egg

Nursing staff. The exact date of egg retrieval depends on how your ovary responds to the FSH medication. Therefore, at short notice (generally 1 ½ days) you must be prepared to stop your usual activities (including school and work) for one day. Because you will be sedated for egg retrieval which is scheduled in the morning, we advise that you rest at home the rest of the day. You will be given specific instructions about days you need to restrict physical activity and sexual intercourse. You will have a follow-up exam with an NYUFC physician about two weeks after the egg retrieval.

Side Effects and Risks Involved

The daily blood sampling and hormone injections are generally well tolerated. However, some women experience discomfort, redness or small bruises or rarely, infection at the injection sites. Treatment side effects from the FSH medication may include breast tenderness, fluid retention, a bloated feeling, moodiness and tenderness in your ovaries. There may be an increase in the size of the ovaries; less common side effects include fluid retention in the abdomen and chest. Extremely rare side effects are clotting in the vessels or torsion (twisting) of the ovaries. NYUFC physicians will routinely regulate your medications to minimize discomfort and side effects, but in some cases this cannot be avoided. There are rare risks with the egg retrieval procedure such as infection and injury to the bowel, blood vessels, or other structures. Such an injury might necessitate open abdominal surgery with a hospital stay to control bleeding or to repair or remove the ovary, but this is very uncommon.

Psychological Support

Oocyte donors feel a great deal of personal satisfaction in giving infertile families the opportunity to achieve a pregnancy. It is common, however, to feel some ambivalence or uncertainty regarding your decision or to experience anxiety about the medical procedures or the results of any of your tests. A NYUFC mental health professional is available throughout the process to offer emotional support and counseling.

Compensation

We realize that oocyte donation is a commitment that requires a significant contribution of your time. We are willing to compensate you for the inconvenience that you experience. Compensation is currently \$8000 for a completed oocyte donation cycle. You will receive an IRS form 1099 for this compensation. You may donate eggs more than once, however, you must wait two months between each donation cycle.

Application Form

Please complete the attached application form and be sure to include all documents requested. Thank you for your interest in participating in our oocyte donation program. Please review the questions carefully and follow the instructions provided.



- Use blue or black ink only and write neatly.
- Please answer all of the questions truthfully and to the best of your ability. Your application will be de-identified from personal identifiers and a copy will be given to prospective recipients.
- Sign the Personal History Form and Affidavit Form.
- Attach a recent photograph of yourself to the application.

Donor applicants must also provide the following:

For US Citizens

- Photocopy of Social Security Card, or State Tax ID **AND**
- Copy of a valid photo ID (i.e. driver's license or passport)

For Resident Aliens

- Photocopy of Social Security Card or Tax ID **AND**
- Copy of your valid "green card"

For Non-Resident Aliens

- Photocopy of Social Security Card or Tax ID **AND**
- Copy of valid visa

Once received, your application will be screened by our medical team. You will be contacted, either through mail or by phone, within two weeks.

Your Application must contain the required attachments or it will not be processed!

For questions, please contact:

Donor Egg Coordinator

(212) 263-0011 or (212) 263-0054



Egg Donor Application and Medical History Form

Date Applied: _____ Donor #: _____

Please put thought into your responses and write legibly. A copy of your application with identifying information deleted will be given to prospective recipients.

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Provide your Social Security or T.I.N. Number : _____

Are you a U.S. Citizen? Yes No Country of Origin? _____

Are you a Resident Alien? Yes No If yes, provide your alien number: A _____

Please include a copy of your social security card or TIN & green card along with the application

Are you a non-resident Alien? Yes No If yes, what type of VISA? _____

Please include a copy of your visa & work permit information with the application

How did you hear about our program?

Magazine (name):

Friend (name):

Newspaper (name):

Internet

PATH train

Movie Ad (name & location of theatre):

Radio ad (name of station):

Craigslist

Did you see us on Facebook? Yes No

Directed Donor Name of Recipient: _____

Although children born of my ovum donation cannot now contact me, should the laws change, I would be willing to be contacted when such children reach maturity (usually age 18-21).

This is not a binding decision, but merely my current inclination.

Yes No Undecided Any comments: _____

Would you be willing to provide a childhood photo of yourself, (between age 2-8) for prospective recipients to view? (They will NOT be permitted to keep this photo).

Yes No If yes, please attach a childhood photo of yourself (age 2-8)

Why are you interested in becoming an egg donor ? _____

Personal Information: Place of Birth: _____
Race: _____

Ethnic origin, (i.e.: Italian, Swedish, African, etc.)

Ethnic Origins of your Mother's Family	Ethnic Origins of your Father's Family

Your Religion: _____ Mother's Religion: _____ Father's Religion: _____

If Jewish: Ashkenazi Sephardic

Physical Characteristics

Height: _____ Weight: _____ Build: Small Medium Large
(Please be accurate)

Eye Color: _____ Natural Hair Color: _____

Hair Texture (Check all that apply):

Straight Wavy Thick Thin Fine Curly Coarse

Do you wear glasses or contact lenses? Yes No If yes, at what age were they prescribed? _____

Did you wear braces ? Yes No

Do you have any dental abnormalities ? Please describe: _____

Complexion:

Fair Rose Medium Olive Light Brown Medium Brown Dark Brown Ebony

Freckles?

None Few Numerous

Have you ever had Acne? Yes No If yes, at what age? _____ Severity of your acne? _____

Are you: Right Handed Left Handed Ambidextrous

Is your hearing normal ? Yes No

If no, please describe hearing trouble: _____

Family Characteristics

(Please tell us about your family to the best of your ability)

Relative	Alive Yes or No	Present age or age at death	Height	Weight	Size of body frame	Hair color	Eye Color	Skin tone	Medical condition or cause of death?	Occupation	Birth Place
Mother											
Maternal Grandmother											
Maternal Grandfather											
Father											
Paternal Grandmother											
Paternal Grandfather											
Brother/sister 1											
Brother/sister 2											
Brother/sister 3											
Brother/sister 4											
Brother/sister 5											
Brother/sister 6											
Brother/sister 7											
Your own Son/daughter 1											
Your own Son/daughter 2											
Your own Son/daughter 3											

If you have additional siblings or children of your own please attach an additional sheet of paper and include their characteristics.

Education and Social History

High School (# years) 1 2 3 4 GPA _____ (Based upon 3 4 point scale)
High School G.E.D. _____

College/University (# years) 1 2 3 4 GPA _____ (Based upon 3 4 point scale)

Study Major : _____ Degree Obtained: _____

Post Graduate Major: _____ Post Graduate Degrees: _____

Please list any Scholastic achievements or awards received: _____

Are you or have you been a member of any Honor Societies ? _____

In which area(s) of study did you excel ? _____

Are you fluent in languages other than English? If so, which: _____

Musical Ability

Have you studied music ? Yes No If yes, number of years studied? _____

Musical Ability: Gifted Above Average Average Fair Tone Deaf

Do you play an instrument ? Yes No If yes, what instrument(s) _____

Athletic Activity

Are you athletic ? Yes No

What is your level of physical activity ? Athletic Active Occasionally active Inactive

Have you excelled in physical activities ? If so, please describe: _____

Do you currently participate in sports or physical activities ? _____

Artistic Ability

Have you studied art or do you have any artistic ability ? Yes No

If yes, please describe your artistic ability: _____

Please list any volunteer activities or community service: _____

Please list your hobbies or any special talent you may have or things you enjoy doing in your spare time:

How would you describe your personality ? _____

Work/Occupation History (check all that currently apply)

- I am not currently working.
- I currently work part time.
- I am currently working full time.
- I currently work in the home.
- I am currently a full time student.
- I am currently a part time student.
- Other: explain: _____

Current Occupation: _____

What type of work have you done in the past ? _____

What are your ambitions for yourself over the next five years ? _____

Social History (Check all that currently apply)

Cigarettes/Tobacco

- I don't smoke.
- I currently smoke _____ cigarettes per day.
- I used to smoke, but no longer do.

Alcohol

- I never drink alcohol. I drink only occasionally. I drink regularly.

What type of alcoholic beverages do you drink? _____

How many drinks (beer, wine, or alcohol) do you consume Per day _____? Per week _____? Per month _____?

Drug Usage

- I have never used illegal drugs.
 - I have tried drugs at least once in the past.
 - I used to use drugs regularly but don't anymore.
 - I currently inject illegal drugs or I have injected illegal drugs within the past 12 months.
 - Have you ever shared needles when injecting drugs ? Yes No
- Have you ever used marijuana, heroin, cocaine, LSD, amphetamines, barbiturates...other? Yes No
- If yes, please give details and date last used: _____

Reproductive Health and Sexual History

How old were you when you first began to menstruate? _____

How many days between one period to the next? _____ Is your menstrual cycle? Regular
 Irregular

Are you currently taking oral contraceptives? If yes, which brand and for how long? _____

Have you donated your eggs before? Yes No How many times? 1 2 3 4 5

Where did you donate your eggs? _____

Pregnancy History

- ❖ Have you been pregnant? Yes No
- ❖ If yes, how many times have you been pregnant? _____
- ❖ Have you ever carried a pregnancy full term? Yes No
- ❖ If yes, were there any complications with gestation or delivery? Yes No
- ❖ What were the complications: _____
- ❖ How many times have you given birth? 1 2 3 4 5 More
- ❖ Has every delivery resulted in a live birth? Yes No
- ❖ If no, please explain: _____

Please answer the following questions:		Yes	No
1	Did your mother take DES while she was pregnant with you?		
2	Have you ever been told you are infertile?		
3	Is there a history of infertility in your family?		
4	Have you ever used intravenous drugs or had a sexual partner that did so?		
5	Have you ever used an injectable drug or had a sexual partner that did so?		
6	Are you currently taking injectable medication or do you have a sexual partner that does so?		
7	Have you engaged in prostitution at any time since 1977?		
8	Have you been involved sexually with anyone during the past six months that has engaged in prostitution at any time since 1977?		
9	Have you been sexually active during the past six months		
10	Are you currently sexually active?		
11	Are you in a monogamous relationship? If no, how many sexual partners have you had during the past six months?		
12	Have you had more than 10 sexual partners?		
13	Have you had sexual relations with a partner that is suspected or known to be HIV positive?		
14	Have you ever had sexual relations with a man that has engaged in anal intercourse or oral sex with another man? If yes, when was the last time?		
15	Have you had sexual relations with a gay or bisexual man? If yes, when?		
16	Have you ever received a blood transfusion? If yes, when?		
17	Have you ever received factor VII or factor IX concentrates (blood transfusion) that was not heat-treated or otherwise vial inactivated? If yes, when?		
18	Do you have any tattoos or piercings? If yes when did you receive the last one?		
19	Have you been exposed to known or suspected HIV, Hepatitis B or Hepatitis C Virus, infected blood through percutaneous inoculation or through contact with an open wound or mucous membrane? If yes, When?		
20	Have you ever been diagnosed with Creutzfeldt-Jacob Disease or any other form of CJD?		
21	Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology?		
Please answer the following questions:		Yes	No

22	Have you ever had a blood relative diagnosed with CJD?		
23	Have you ever received a dura mater transplant?		
24	Have you spent three months or more cumulatively in the United Kingdom (U.K.) from the beginning of 1980 through the end of 1996?		
25	Are you a current or former U.S. military member, civilian military employee, or dependent of a military or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, Netherlands) for 6 months or more from 1980 through 1990 or elsewhere in Europe (Greece, Turkey, Spain, Portugal, Italy) for 6 months or more from 1980 through 1996?		
26	Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this includes time spent in the U.K. from 1980-1996)?		
27	Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?		
28	Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?		
29	Have you ever been refused as a blood donor? If yes, Why?		
30	Have you ever been immunized against Hepatitis B? If yes, When?		
31	Have you had close contact, i.e. sexual intimacy, shared a bathroom or a kitchen, with someone suspected or known to be positive for Hepatitis B or Hepatitis C?		
32	Have you been immunized against small pox in the past five years?		
33	Have you had close contact with someone who has had a cell, tissue or organ transplant from an animal?		
34	Have you ever been diagnosed with or treated for West Nile virus? If yes, When?		
35	Have you ever been diagnosed with or treated for Severe Acute Respiratory Syndrome (SARS)? If yes, When?		
36	Have you been exposed to radiation or toxic chemicals in your work or personal life? i.e. lead, mercury and gold		
37	Have you been bitten by an animal suspected of having rabies within the past 12 months?		
38	Have you traveled outside the United States in the past two years? If yes, where and when?		

Have you ever experienced the following conditions? :

Yes No

Have you experienced unexplained weight loss?		
Have you ever had a fever of unexplained origin?		
Have you ever had Kaposi Sarcoma?		
Have you ever had Pneumocystic Pneumonia?		
Have you ever had sexual relations with anyone that had the above symptoms or diseases? If Yes, Please specify:		

Medical History

Do you have any medical illnesses (i.e. asthma, diabetes, seizure disorders, tuberculosis, etc.) ?

List all Surgeries: _____

Do you have any allergies (food, pollen, bee stings, etc.)? Please list:

Do you have any allergies to medications? Please list:

Describe any childhood allergies you may have outgrown :

List medications including prescription, over the counter, vitamins or herbs that you are currently taking:

Are there medications you have taken in the past five years that are not listed above? If so, please list:

Have you ever sought psychological counseling? Yes No

Have you, or are you currently taking medication for a psychological condition? Yes No

If yes, what medications have you, or are you currently taking? _____

Have you ever attempted suicide? _____

Please read through the following list of medical conditions. Indicate which (if any) condition(s) apply to you or your family members. Consider each condition carefully and note the age at which the condition appeared.

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
HEART							
Hardening of the Arteries							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Mitral Valve Prolapse							
Stroke							
BLOOD							
Anemia							
Hemophilia or other Bleeding problem							
HIV/AIDS							
Immune Deficiency or disease							
Leukemia							
Other blood disorder							
Prolonged Fever							
Sickle-Cell Anemia							

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
RESPIRATORY							
Asthma							
Hay Fever							
Emphysema							
Lung Cancer							
Other Lung Disease							
Pneumonia							
Tuberculosis							
GASTROINTESTINAL							
Digestive system Cancer or Disease							
Colon Cancer							
Crohn's Disease							
Cystic Fibrosis							
Gall Stones							
Hepatitis A (infectious)							
Hepatitis B (Serum)							
Hepatitis C							
Other Liver Disease							
Ulcerative Colitis							
Ulcer of stomach or duodenum							
METABOLIC /ENDOCRINE							
Adrenal Dysfunction or disorder							
Diabetes mellitus							
Disease of Urinary tract, urethra or bladder							
Goiter							
Human Growth Hormone administration							
Hyperactivity							
Hypoglycemia							
Thyroid Cancer							
Thyroid Disease							
Rectal disorder							
GENITAL REPRODUCTIVE SYSTEM							
Breast Cancer							
Cervical Cancer							
Chlamydia							
Genital Warts							
Gonorrhea							
Hemophilus							
Herpes I or II							
Hypospodiasis							
Ovarian Cysts							
Pelvic Inflammatory Disease							
Testicular or Prostate Cancer							
Syphilis							
Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset

GENITAL REPRODUCTIVE SYSTEM							
Trichomonas							
Undescended testicle							
Urogenital tuberculosis							
Uterine or Ovarian Cancer							
Uterine Fibroids							
NEUROLOGICAL							
ADD or ADHD							
Autism							
Cerebral Palsy							
Degenerative neurologic disease							
Disorder of the spinal cord							
Epilepsy							
Gaucher's Disease							
Huntington's Disease							
Hydrocephalus							
Learning disabilities/disorders							
Mental retardation							
Migraines							
Multiple Sclerosis							
Senility before age 50							
Wilson's Disease							
Other nervous system diseases							
MENTAL HEALTH							
Alcoholism							
Anxiety Disorder							
Attempted Suicide							
Mania							
Bi-polar Disorder							
Depression							
Drug abuse/misuse or addiction							
Eating Disorders							
Panic Attacks							
Schizophrenia							
MUSCULAR/BONES/JOINTS							
Arthritis							
Cleft Lip or Cleft Palate							
Club Foot							
Deformity of the Spine							
Dwarfism							
Gout							
Hereditary lower back disease							
Lupus							
Muscular Dystrophy							
Osteoporosis							
Spinabifida							
Other Chronic muscle disease							

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
SIGHT/ SOUND/ SMELL							
Any disorder of sight, sound or smell							
Cataracts before age 50							
Colorblindness							
Congenital Deafness before age 60							
Deformity of the ear							
Deviated Septum							
Glaucoma							
SKIN							
Acne							
Eczema							
Pigmentation Disorders							
Skin Cancer							
Other skin disorders							
OTHER BIRTH DEFECTS							
Any other birth defects:							
OTHER							
Any Conditions not mentioned:							

Do you have any siblings that died in infancy or childhood? If so, what was the cause?

Are there any known genetic diseases or conditions that run in your family? Yes No

If yes, please explain: _____

Have you or any family member experienced recurring and/or chronic physical symptoms that have not yet been evaluated by a physician? Please include symptoms even if you don't consider them serious.

❖ I, the undersigned, have read the oocyte donation information. I hereby acknowledge that all the information that I have provided on this oocyte donation personal history form has been entered fully and correctly, to the best of my knowledge.

Signature _____

Date _____

To be completed by the Donor Coordinator or Donor Administrative Coordinator:

Name

Date application was received