Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO USE OF OVA FROM A KNOWN DONOR WHO HAS RISK FACTORS FOR, OR EVIDENCE OF, INFECTION WITH CERTAIN COMMUNICABLE DISEASES (Directed Donation)

I, _____, and _____, my partner, if applicable, are participating in assisted reproduction procedures so that I can become pregnant utilizing ova from _____, a person who is known to me (but who is not my spouse or intimate partner).

California law and/or federal regulations require that an ovum donor be tested and/or screened for certain communicable diseases. Under California law, use of ova from a donor who tests reactive for HIV, HTLV, Hepatitis B, Hepatitis C, or Syphilis is not permitted. It is the policy of the REI Clinic not to permit use of ova from a known donor who has risk factors, or tests reactive, for Gonorrhea or Chlamydia. Use of ova from a known donor who shows risk factors for, or evidence of infection with, the following diseases is permitted, provided the recipient is advised of the medical risks and consents to the use. The required testing and screening of the ovum donor named above show that she has risk factors for, or evidence of infection with, the disease(s) checked below.

OVUM DONOR

	Screening	Testing
Hepatitis B	❑	N/A
Human transmissible spongiform encephalopathy, including Creutzfeldt-Jacob Disease ("CJD") and variant CJD	❑	N/A
Risk of diseases associated with xenotransplantation	❑	N/A
Cytomegalovirus	❑	N/A
Other (specify)	❑	❑

The nature of the disease(s) checked above, including symptoms and severity, has been explained to us. We have also received an explanation of the risk of transmission of the disease to the woman and (if pregnancy results) to the fetus, based upon the donor's specific risk factors for, or evidence of, infection. We have been advised of the measures (if any) that can be taken to reduce the risk. We have also been advised of the available alternatives to use of this donor, and have had all of our questions answered.

Having received this information, we nonetheless wish to proceed with assisted reproductive procedures utilizing the oocytes or ova of the donor named above. Accordingly, we hereby consent to the use of oocytes or ova from a donor who has risk factors for, or evidence of infection with, the disease(s) indicated above. We hereby release the Stanford REI Center, Stanford Hospital and Clinics, Stanford University, and the physicians, employees and agents thereof from any liability for any illness or harm resulting from or associated with use of oocytes or ova from the donor named on page 1 of this form.

Signature of Patient	Date	Time
Signature of Partner	Date	Time
Signature of Witness	Date	Time

TO BE COMPLETED BY PHYSICIAN

I certify that I have explained to the three persons whose signatures appear above the nature of the disease(s) checked above, including symptoms and severity. I have also explained the risk of transmission of disease to the patient and to the fetus, based upon the designated donor's specific risk factors for, or evidence of, infection. I have further advised of the measures (if any) that can be taken to reduce this risk, and of the available alternatives with regard to choice of an ovum donor. I have offered to answer all of their questions regarding these matters.

Signature of Physician	Date	Time