Medical Record Number

Patient Name

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

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

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

SPERM DONOR

	Screening	Testing
Syphilis	❑	❑ If this box is checked, the donor must undergo treatment for syphilis PRIOR TO donating sperm. The REI Clinic requires documentation of completion of treatment and a current non-reactive test before donation can proceed.
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(s) to the recipient of the sperm 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 and have had all of our questions answered.

Having received this information, we nonetheless wish to proceed with assisted reproductive procedures utilizing the sperm of the donor named above. Accordingly, we hereby consent to the use of sperm 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 sperm from the donor named on page 1 of this form

_____	_____	_____
Signature of Recipient	Date	Time
_____	_____	_____
Signature of Recipient's Partner	Date	Time
_____	_____	_____
Signature of Witness	Date	Time

TO BE COMPLETED BY PHYSICIAN

I certify that I have explained to the 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 the disease(s) to the recipient of the sperm and (if pregnancy results) to the fetus, based upon the 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 a sperm donor. I have offered to answer all of their questions regarding these matters.

_____	_____	_____
Signature of Physician	Date	Time