

**Piedmont Reproductive Endocrinology Group (PREG)
INFORMED CONSENT TO DONATE EMBRYOS ANONYMOUSLY/
WAIVER OF LIABILITY**

Piedmont Reproductive Endocrinology Group (PREG)
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We understand that embryos or zygotes created with our genetic material (the "Embryos") are currently in cryostorage. We also understand that the purpose of this document is to donate the Embryos to an anonymous recipient(s) for the purpose of assisting one or more women in achieving a pregnancy. Such a pregnancy may be extremely difficult or impossible for the recipient to achieve without the use of donated embryos. Therefore, the Embryos will be placed into the reproductive tract of one or more recipients in order to attempt to establish a pregnancy.

We, _____ (male) and _____ (female) do hereby consent to the **anonymous donation of our cryopreserved embryos** for implantation to assist another couple as provided in this agreement.

We agree to donate all of our cryopreserved zygotes or embryos currently in storage to Piedmont Reproductive Endocrinology Group (PREG). We understand that our donation will be anonymous. We understand that we have thirty (30) days from the date we sign this agreement in which to change our minds and notify PREG that we wish to revoke the donation of our cryopreserved embryos. In the case of anonymous donation, either a recipient couple may choose our embryos, or a physician affiliated with PREG will choose a recipient or recipients that he in his sole discretion considers appropriate for receipt of our Embryos. This recipient(s) will be anonymous and we have no right to learn of the identity of the recipient(s) and PREG will not disclose our identity to the recipient. The physician is authorized to use his best judgment in selecting a recipient(s) for the Embryos. We understand that our Embryos will remain in cryostorage until they are selected by a recipient couple or until a suitable recipient is found. We agree that our embryos will NOT be used for a "known" or 'open' donation (i.e. non-anonymous). We understand that PREG will not perform "known", or 'open' donation (i.e. non-anonymous) embryo transfers with our embryos and that if we desire "open" donation we will need to pursue another practice to provide that service.

The FDA has strict regulations for tissue donation, including embryos. We understand and agree to complete a questionnaire that addresses the male and female donors' physical characteristics, education, personal health, and family health that will be made available to the potential recipient couple of your embryos. We also agree to complete a risk factor questionnaire, medical health history, and physical exam assessment as required by current FDA guidelines. If not already done, we understand that we will be asked to have blood testing done to insure that we have not contracted certain infections, such as hepatitis B and C, HIV, and Syphilis, that could potentially also be present in our embryos. **We understand that we may decline the physical exam and labs and our embryos could still be donated.** There is a small risk of complications from drawing blood, such as discomfort and infection. Alternatively, if another laboratory or health care facility has completed the required tests, the donor agrees to execute a release allowing PREG to access the records. Donor agrees that if for any reason, including medical testing, screening, or lack of market demand, embryo donation is not appropriate or likely to take place, as determined in the sole discretion of PREG, Donor's embryos will not be donated and instead will be disposed of according to applicable ethical and legal standards. Donor understands that PREG and the Recipient rely upon Donor's representations that the embryos stored are the Donor's own; and Donor has truthfully provided all information referred to in this paragraph of this agreement. Donor shall be liable for any damages to PREG or Recipient directly or indirectly caused by Donor's misrepresentations to PREG and/or Recipient.

INITIALS _____ / _____

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There is also a risk that we may suffer from psychological problems as a result of donating our embryos. The American Society of Reproductive Medicine currently recommends that couples undergo counseling prior to embryo donation. PREG does not require this, but we would be glad to assist you in finding a counselor should you so desire.

We realize that the purpose of embryo donation is to help another woman achieve pregnancy, but that there is no guarantee that a pregnancy will result from the transfer of our Embryos. We realize that the Embryos may not survive the shipping (if not already in storage at PREG) or thawing procedure and/or that they may not develop after the thaw and that no transfer may occur, and that a successful transfer may not result in a successful pregnancy. We also acknowledge that inadvertent loss or damage of the Embryos may occur.

Each party hereby agrees to irrevocably waive, release and relinquish any and all rights, claims or causes of action of any kind, whether known or unknown and whether now existing or occurring in the future, over and against PREG, our physicians, the Medical Director, and all employees, officers, directors, contractors and agents of such parties and agrees to protect, defend, hold harmless and indemnify such parties from and against any and all expenses, claims, actions, liabilities, attorney's fees, damages, losses, penalties, fines, and interest of any kind whatsoever (including without limiting the foregoing, death of or injury to persons or Embryos and damage to property) actually or allegedly resulting from or connected with the Embryos, the donation of the Embryos, the cryostorage of the Embryos or any other matters contemplated in this agreement.

We understand that we will not be informed of whether or not a pregnancy has occurred with our Embryos, and we agree not to seek such information. We further agree that we will receive no compensation for donation of our Embryo(s). We understand that psychological counseling is recommended by some authorities prior to embryo donation, and that we will inform our physician if we desire such counseling, which counsel would be made available at our expense. We further acknowledge that there may be unknown psychological risks both to us and to our offspring in connection with the procedures contemplated herein, and we agree to assume those risks.

Upon execution of this Agreement and completion of the embryo donation protocol, any and all rights we (donor) have with respect to the embryos will terminate, regardless of whether or not a donation ultimately occurs. We do hereby relinquish any and all rights, titles, and interests to the Embryos(s) and any child or children that may result from the transfer of the Embryo(s). However, in vitro fertilization and use of donated cryostored embryos are new medical procedures, the legal implications of which have not been fully considered by the courts and legislatures. For these reasons, PREG cannot make guarantees or promises to either Recipient or Donor about the enforceability of parental rights. PREG strongly advises Donor to obtain legal counsel with respect to parental rights and responsibilities regarding resulting offspring. By signing this agreement, donor agrees that Donor has had ample opportunity to review this agreement with legal counsel of Donor's choosing, and donor has ultimately and freely decided whether to procure such legal counsel. We understand the above information and have had any questions answered to our satisfaction by our physician and/or the staff of PREG.

We hereby agree, acknowledge and consent that any and all children resulting from the Embryos shall be the legal children of the birth parents for all intents and purposes. We further agree to execute any other or further documentation and grant any other or further consents to the extent any are necessary or advisable in the future in order to effect the purpose of this agreement that such children be deemed the children of the birth parents under the law whether by statute, presumption, adoption, legitimation or such other methods that may be or may become available.

If future statutes, regulations, court decisions, or other laws make the intended donation illegal or otherwise in violation of applicable law, as determined in the sole discretion of PREG, PREG will not allow donation and instead will dispose of the Embryos in accordance with applicable ethical and legal standards.

INITIALS _____ / _____

Piedmont Reproductive Endocrinology Group (PREG)
Screening and Testing of Donor Embryos Consent
-Female Egg Donor

Relating to Tissue ID # _____

FEMALE

To donate your embryos we strongly recommend the following four items be performed per FDA regulations. Please check the box that you either agree or decline to have the test/screening measure performed. I understand that declining any or all of the screening or testing below will NOT affect being able to donate embryos.

- 1) Blood tests performed according to FDA regulations for HIV 1 Ab, HIV 2 Ab, Hepatitis B sAg and Core Ab, Hepatitis C Ab, HTLV I, HTLV II, Syphilis (RPR)

I agree

I decline

- 2) Donor physical assessment performed according to FDA regulations for donors

I agree

I decline

- 3) Donor risk assessment questionnaire performed according to FDA regulations for donors

I agree

I decline

- 4) Medical health history recording performed according to FDA regulations for donors

I agree

I decline

Signature: _____

Date: _____

Print Name: _____

Piedmont Reproductive Endocrinology Group (PREG)
Screening and Testing of Donor Embryos Consent
-Male Sperm Donor

Relating to Tissue ID # _____

MALE

To donate your embryos we strongly recommend the following four items be performed per FDA regulations. Please check the box that you either agree or decline to have the test/screening measure performed. I understand that declining any or all of the screening or testing below will NOT affect being able to donate embryos.

- 1) Blood tests performed according to FDA regulations for HIV 1 Ab, HIV 2 Ab, Hepatitis B sAg and Core Ab, Hepatitis C Ab, HTLV I, HTLV II, Syphilis (RPR), CMV total Ab
 I agree
 I decline
- 2) Donor physical assessment performed according to FDA regulations for donors
 I agree
 I decline
- 3) Donor risk assessment questionnaire performed according to FDA regulations for donors
 I agree
 I decline
- 4) Medical health history recording performed according to FDA regulations for donors
 I agree
 I decline

Signature: _____

Date: _____

Print Name: _____

Piedmont Reproductive Endocrinology Group (PREG) EMBRYO DONOR FAMILY INFORMATION

Please type or use black ink for the information on this sheet so the adoptive family may have some insight into the background of the child that may result from your frozen embryos. Please DO NOT list any identifying information such as a name, birthday, city, business, etc.

Husband

Physical Characteristics

Height: _____ Weight: _____ Age: _____

Race (Circle all that apply): Caucasian, Black, American Indian, Asian, Hispanic

Other: _____

Family Ethnicity (Circle all that apply): English, Irish, Italian, Greek, Spanish, Swedish, German, Chinese, Japanese, Other: _____

Are you a twin? Yes: _____ (identical, fraternal) No: _____

Hands: Right handed, Left handed, Ambidextrous

Hair (circle most appropriate from each line):

Color at birth: Blonde, Brown, Black, Red, other: _____

Present Color: Blonde, Brown, Black, Red, other: _____

Shade: Light, Medium, Dark

Texture: Wavy, Straight, Curly

Body: Thin, Medium, Thick

Eye Color: Blue, Green, Hazel, Brown, Black, other: _____

Complexion: Fair, Medium, Dark

Body Build: Small, Medium, Large

MEDICAL HISTORY:

YES

NO

Acne	_____	_____
Bleeding Tendency or Problem	_____	_____
Thyroid Disease	_____	_____
Prostrate Disease	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Problems	_____	_____
Hepatitis	_____	_____
Mitral Valve Prolapse	_____	_____
Kidney Disease	_____	_____
Liver Disease	_____	_____
Urinary Tract Infections	_____	_____
Blood Clots in Legs or Lungs	_____	_____
Psychological or Emotional Problems	_____	_____
Depression	_____	_____
Alcohol/ Drug Abuse	_____	_____

**Piedmont Reproductive Endocrinology Group (PREG)
EMBRYO DONOR FAMILY INFORMATION
HUSBAND Continued**

GENETIC / FAMILY HISTORY

Do any members of your immediate family or extended family (cousins, aunts, uncles, grandparents) have: (Please circle all that apply to your family)

- | | |
|------------------------------|----------------------------|
| Down' Syndrome | Alzheimer's |
| Tay Sach | Mental Illness |
| Thalassemia | Depression |
| Schizophrenia | Diabetes |
| Huntington's Disease | Arthritis |
| Hemophilia | Cystic Fibrosis |
| Muscular Dystrophy | Marfan's Syndrome |
| Neurofibromatosis | Hereditary Anemia |
| Von Recklinghausen's Disease | Sickle Cell Anemia |
| Fragile X Syndrome | Mental Retardation |
| Congenital Heart Disease | Heart Attack before age 50 |

Please list type of relationship to each of the above: _____

EDUCATION:

Highest Educational Degree Obtained (Please circle one):
Middle School, High School, College, Graduate School, Post Graduate School

TALENTS:
Artistic Talents (circle all that apply): Painting, Drawing, Sculpting, Carving, Singing, Songwriting, Dancing, Writing, Acting, Other: _____

WIFE

Physical Characteristics

Height: _____ Weight: _____ Age: _____

Race (Circle all that apply): Caucasian, Black, American Indian, Asian, Hispanic

Other: _____

Family Ethnicity (Circle all that apply): English, Irish, Italian, Greek, Spanish, Swedish, German, Chinese, Japanese, Other: _____

Are you a twin? Yes: _____ (identical, fraternal) No: _____

Hands: Right handed, Left handed, Ambidextrous

**Piedmont Reproductive Endocrinology Group (PREG)
EMBRYO DONOR FAMILY INFORMATION
WIFE Continued**

Hair (circle most appropriate from each line):

Color at birth: Blonde, Brown, Black, Red, other: _____
 Present Color: Blonde, Brown, Black, Red, other: _____
 Shade: Light, Medium, Dark
 Texture: Wavy, Straight, Curly
 Body: Thin, Medium, Thick

Eye Color: Blue, Green, Hazel, Brown, Black, other: _____
Complexion: Fair, Medium, Dark
Body Build: Small, Medium, Large

<u>MEDICAL HISTORY:</u>	<u>YES</u>	<u>NO</u>
Acne	_____	_____
Bleeding Tendency or Problem	_____	_____
Thyroid Disease	_____	_____
Breast Disease	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Problems	_____	_____
Hepatitis	_____	_____
Mitral Valve Prolapse	_____	_____
Kidney Disease	_____	_____
Liver Disease	_____	_____
Urinary Tract Infections	_____	_____
Blood Clots in Legs or Lungs	_____	_____
Psychological or Emotional Problems	_____	_____
Depression	_____	_____
Alcohol/ Drug Abuse	_____	_____

GENETIC / FAMILY HISTORY

Do any members of your immediate family or extended family (cousins, aunts, uncles, grandparents) have: (Please circle all that apply to your family)

- | | |
|------------------------------|----------------------------|
| Down' Syndrome | Alzheimer's |
| Tay Sach | Mental Illness |
| Thalassemia | Depression |
| Schizophrenia | Diabetes |
| Huntington's Disease | Arthritis |
| Hemophilia | Cystic Fibrosis |
| Muscular Dystrophy | Marfan's Syndrome |
| Neurofibromatosis | Hereditary Anemia |
| Von Recklinghausen's Disease | Sickle Cell Anemia |
| Fragile X Syndrome | Mental Retardation |
| Congenital Heart Disease | Heart Attack before age 50 |

Please list type of relationship to each of the above: _____

Piedmont Reproductive Endocrinology Group (PREG)
EMBRYO DONOR FAMILY INFORMATION
WIFE Continued

EDUCATION:

Highest Educational Degree Obtained (Please circle one):

Middle School, High School, College, Graduate School, Post Graduate School

TALENTS:

Artistic Talents (circle all that apply): Painting, Drawing, Sculpting, Carving, Singing,
Songwriting, Dancing, Writing, Acting, Other: _____

Risk Factor Questionnaire

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

Please answer the following questions truthfully and to the best of your knowledge.

	For Office Use Only	
1. Have you ever been in a same sex relationship or had sex with a male within the past 5 years who has had sexual contact with another male?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
2. Have you ever used injectable drugs (with a needle including intravenous, intramuscular and subcutaneous) for non-medical use, including steroids, not prescribed by a doctor in the past 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
3. Have you had sexual contact with a person who has hemophilia or related clotting disorders or has received human-derived clotting factor concentrates in the past 5 years? Or have you received human derived clotting factor concentrates once to treat an acute bleeding event in the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
4. Have you ever had sex in exchange for money or drugs in past the 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
5. Have you had sex with any person described in the previous 4 questions, with someone who has been in prison, or with any person known or suspected to have HIV infection, clinically active hepatitis B or C infections in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
6. Have you ever been exposed to known or suspected HIV or Hepatitis A, B, or C infection through a needle stick, open wound or mucous membrane in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
7. Have you had contact with blood that is known or suspected to be infected with HIV, Hepatitis B and/or Hepatitis C virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
8. Have you been incarcerated (juvenile detention, lock-up, jail, or prison) for more than 72 consecutive hours during the previous 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
9. Have you had <u>close contact</u> (i.e. living in the same household where sharing of kitchen and bathroom facilities occurs regularly, dormitories, etc) with a person with Hepatitis B or clinically active viral Hepatitis C in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
10. Have you undergone ear or body piercing or tattooing within the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
11. Were you ever told you had viral hepatitis (either B or C)? Or a positive screening for viral hepatitis that was not identified as caused by Hepatitis A, EBV, or CMV?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
12. Have you recently been diagnosed with or treated for a blood infection (sepsis), positive blood cultures or elevated white blood cell count?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
13. Have you received the Small Pox Vaccination (vaccinia virus) within the past 8 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
14. Have you had any skin rashes and/or skin sores since your Small Pox Vaccination or skin rashes/sores after contact with a person who has received the vaccination within past 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
15. Have you been diagnosed with West Nile Virus (WNV) or suspected of having WNV or tested positive or reactive for WNV infection using a WNV NAT donor screening test in the previous 120 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
17. Have you been diagnosed or treated for Syphilis or any other sexually transmitted disease within the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
18. Have you been diagnosed or treated for Neisseria Gonorrhoea or Chlamydia trachomatis infection or any other sexually transmitted disease in the preceding 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
19. Have you been diagnosed with Creutzfeldt-Jakob Disease (CJD) or "variant CJD" or do you have a blood relative diagnosed with CJD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
20. Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

Risk Factor Questionnaire

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

21. Have ever you received Human Pituitary Growth Hormone or received a dura mater (brain covering) graft?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
23. Have you visited or lived in United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, Channel Islands, Gibraltar or Falkland Islands) for 3 months or more from 1980 through 1996?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
24. Were you a member of the military or a military dependent stationed for 6 months or more cumulatively in Northern Europe (Belgium, the Netherlands, Germany) between 1980-1990 or Spain, Portugal, Turkey, Italy or Greece between 1980-1996?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
25. Have you visited, lived, or spent 5 years or more cumulatively in Europe since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
26. Have you received a transfusion of blood or blood components in the United Kingdom or France since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
27. Were you or your sexual partner(s) born or ever lived in the African countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
28. Have you ever received a blood transfusion or any medical treatment that involved blood in the countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
29. Have you, your sexual partner, and/or any other member of your household, ever received a transplant (xenotransplantation) or other medical procedure that involves being exposed to live cells, tissues or organs from an animal? Who? _____ (if someone in your household please answer the next question)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
30. If this person is in your household, have you or will you be exposed to blood, saliva, or other body fluids from this person?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
31. Have you ever had a prior positive or reactive screening test for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
32. Have you had unexplained weight loss, night sweats, temperature of > 100.5 degrees for more than 10 days, persistent cough or shortness of breath, persistent diarrhea, persistent white spots or unusual blemishes in the mouth, blue or purple spots on or under the skin or mucous membranes, swollen lymph nodes for longer than one month, or opportunistic infections?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
33. Have you ever had unexplained jaundice, hepatomegaly (enlarged liver), elevated or abnormal liver function tests/labs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
34. Have you had a recent severe illness with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness or paralysis, swollen lymph nodes, eye pain, or skin rash or the trunk of the body?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
35. In the past week, have you had an unexplained fever, headache, fast heart rate or fast breathing or elevated white blood cell (WBC) count on a blood lab?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
36. In the past week, have you been diagnosed with sepsis (includes but not limited to, bacteremia, septicemia, sepsis syndrome, systemic infection, or septic shock)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
37. Have you ever had a prior positive or reactive screening test for Human T-lymphotropic virus (HTLV) types 1 or 2, unexplained paraparesis, and/or Adult T-cell leukemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
38. Have you received a rabies shot in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
39. Have you ever used/been injected with Bovine (beef) insulin?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
40. Have you been diagnosed with Hepatitis A or received gamma globulin shot for Hepatitis A exposure?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

Risk Factor Questionnaire

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

41. Have you been exposed to, treated for, or suspected of having SARS in the past 28 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
42. In the past 14 days have you cared for, lived with, or had direct contact with blood, saliva, or other body fluids from someone with SARS or suspected SARS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
43. Have you traveled to or resided in areas affected by SARS within the previous 14 days? (review current listing)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
44. Are you feeling well today and feel that you are generally in good health?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

By signing this form I represent and warrant that I have read the above questions and have answered them truthfully and to the best of my knowledge. If I was uncertain about a question, I was given the opportunity to ask the physician and/or nurse for clarification and then answered the question truthfully and to the best of my knowledge. I understand that I am being asked **not** to participate in any of the above high-risk activities described in the questions contained in this questionnaire (including but not limited to tattooing, body piercing, multiple partners, unprotected sex, recreational drug use, etc.) during the donation cycle (IVF) and will inform the nursing staff if I do. I agree to practice safe sex during this time period to prevent communicable disease exposure and prevent any unwanted pregnancy. I understand that if I do participate in any of the above high-risk activities that I report this to the physicians or nursing staff at Piedmont Reproductive Endocrinology Group (PREG) and that I may be asked to postpone the donation or possibly be excluded from the donor program, IVF gestational carrier cycle or may disqualify cyropreserved embryos from being donated in the future. By participating in any high-risk activities such as those described herein, I understand that legal recourse by the recipient couple or individual receiving the donation is possible should my actions cause any adverse effects. I agree to indemnify, defend and hold harmless PREG, its doctors and employees from any and all claims, losses, liabilities and demands suffered by any of them as a result of my participation in any high-risk activities or behavior and/or any untruthfulness or inaccuracy by me concerning the same.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

For Office Use Only: Do not write below

Eligible

Ineligible

Medical Director: _____ **Date:** _____

Risk Factor Questionnaire (MALE)

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

Please answer the following questions truthfully and to the best of your knowledge.

	For Office Use Only	
1. Have you ever been in a same sex relationship or had sex with a male within the past 5 years who has had sexual contact with another male?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
2. Have you ever used injectable drugs (with a needle including intravenous, intramuscular and subcutaneous) for non-medical use, including steroids, not prescribed by a doctor in the past 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
3. Have you had sexual contact with a person who has hemophilia or related clotting disorders or has received human-derived clotting factor concentrates in the past 5 years? Or have you received human derived clotting factor concentrates once to treat an acute bleeding event in the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
4. Have you ever had sex in exchange for money or drugs in past the 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
5. Have you had sex with any person described in the previous 4 questions, with someone who has been in prison, or with any person known or suspected to have HIV infection, clinically active hepatitis B or C infections in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
6. Have you ever been exposed to known or suspected HIV or Hepatitis A, B, or C infection through a needle stick, open wound or mucous membrane in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
7. Have you had contact with blood that is known or suspected to be infected with HIV, Hepatitis B and/or Hepatitis C virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
8. Have you been incarcerated (juvenile detention, lock-up, jail, or prison) for more than 72 consecutive hours during the previous 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
9. Have you had <u>close contact</u> (i.e. living in the same household where sharing of kitchen and bathroom facilities occurs regularly, dormitories, etc) with a person with Hepatitis B or clinically active viral Hepatitis C in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
10. Have you undergone ear or body piercing or tattooing within the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
11. Were you ever told you had viral hepatitis (either B or C)? Or a positive screening for viral hepatitis that was not identified as caused by Hepatitis A, EBV, or CMV?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
12. Have you recently been diagnosed with or treated for a blood infection (sepsis), positive blood cultures or elevated white blood cell count?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
13. Have you received the Small Pox Vaccination (vaccinia virus) within the past 8 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
14. Have you had any skin rashes and/or skin sores since your Small Pox Vaccination or skin rashes/sores after contact with a person who has received the vaccination within past 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
15. Have you been diagnosed with West Nile Virus (WNV) or suspected of having WNV or tested positive or reactive for WNV infection using a WNV NAT donor screening test in the previous 120 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
17. Have you been diagnosed or treated for Syphilis or any other sexually transmitted disease within the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
18. Have you been diagnosed or treated for Neisseria Gonorrhoea or Chlamydia trachomatis infection or any other sexually transmitted disease in the preceding 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
19. Have you been diagnosed with Creutzfeldt-Jakob Disease (CJD) or "variant CJD" or do you have a blood relative diagnosed with CJD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
20. Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

Risk Factor Questionnaire (MALE)

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

21. Have ever you received Human Pituitary Growth Hormone or received a dura mater (brain covering) graft?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
23. Have you visited or lived in United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, Channel Islands, Gibraltar or Falkland Islands) for 3 months or more from 1980 through 1996?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
24. Were you a member of the military or a military dependent stationed for 6 months or more cumulatively in Northern Europe (Belgium, the Netherlands, Germany) between 1980-1990 or Spain, Portugal, Turkey, Italy or Greece between 1980-1996?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
25. Have you visited, lived, or spent 5 years or more cumulatively in Europe since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
26. Have you received a transfusion of blood or blood components in the United Kingdom or France since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
27. Were you or your sexual partner(s) born or ever lived in the African countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
28. Have you ever received a blood transfusion or any medical treatment that involved blood in the countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
29. Have you, your sexual partner, and/or any other member of your household, ever received a transplant (xenotransplantation) or other medical procedure that involves being exposed to live cells, tissues or organs from an animal? Who? _____ (if someone in your household please answer the next question)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
30. If this person is in your household, have you or will you be exposed to blood, saliva, or other body fluids from this person?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
31. Have you ever had a prior positive or reactive screening test for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
32. Have you had unexplained weight loss, night sweats, temperature of > 100.5 degrees for more than 10 days, persistent cough or shortness of breath, persistent diarrhea, persistent white spots or unusual blemishes in the mouth, blue or purple spots on or under the skin or mucous membranes, swollen lymph nodes for longer than one month, or opportunistic infections?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
33. Have you ever had unexplained jaundice, hepatomegaly (enlarged liver), elevated or abnormal liver function tests/labs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
34. Have you had a recent severe illness with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness or paralysis, swollen lymph nodes, eye pain, or skin rash or the trunk of the body?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
35. In the past week, have you had an unexplained fever, headache, fast heart rate or fast breathing or elevated white blood cell (WBC) count on a blood lab?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
36. In the past week, have you been diagnosed with sepsis (includes but not limited to, bacteremia, septicemia, sepsis syndrome, systemic infection, or septic shock)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
37. Have you ever had a prior positive or reactive screening test for Human T-lymphotropic virus (HTLV) types 1 or 2, unexplained paraparesis, and/or Adult T-cell leukemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
38. Have you received a rabies shot in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
39. Have you ever used/been injected with Bovine (beef) insulin?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
40. Have you been diagnosed with Hepatitis A or received gamma globulin shot for Hepatitis A exposure?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

Risk Factor Questionnaire (MALE)

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

41. Have you been exposed to, treated for, or suspected of having SARS in the past 28 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
42. In the past 14 days have you cared for, lived with, or had direct contact with blood, saliva, or other body fluids from someone with SARS or suspected SARS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
43. Have you traveled to or resided in areas affected by SARS within the previous 14 days? (review current listing)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
44. Are you feeling well today and feel that you are generally in good health?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

By signing this form I represent and warrant that I have read the above questions and have answered them truthfully and to the best of my knowledge. If I was uncertain about a question, I was given the opportunity to ask the physician and/or nurse for clarification and then answered the question truthfully and to the best of my knowledge. I understand that I am being asked **not** to participate in any of the above high-risk activities described in the questions contained in this questionnaire (including but not limited to tattooing, body piercing, multiple partners, unprotected sex, recreational drug use, etc.) during the donation cycle (IVF) and will inform the nursing staff if I do. I agree to practice safe sex during this time period to prevent communicable disease exposure and prevent any unwanted pregnancy. I understand that if I do participate in any of the above high-risk activities that I report this to the physicians or nursing staff at Piedmont Reproductive Endocrinology Group (PREG) and that I may be asked to postpone the donation or possibly be excluded from the donor program, IVF gestational carrier cycle or may disqualify cyropreserved embryos from being donated in the future. By participating in any high-risk activities such as those described herein, I understand that legal recourse by the recipient couple or individual receiving the donation is possible should my actions cause any adverse effects. I agree to indemnify, defend and hold harmless PREG, its doctors and employees from any and all claims, losses, liabilities and demands suffered by any of them as a result of my participation in any high-risk activities or behavior and/or any untruthfulness or inaccuracy by me concerning the same.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

For Office Use Only: Do not write below

Eligible

Ineligible

Medical Director: _____ **Date:** _____