

Specialists In Reproductive Medicine & Surgery, P.A.

www.DreamABaby.com • Fertility@DreamABaby.com

Excellence, Experience & Ethics



Donating Parents Identifying Information

Thank you for donating your embryos!!

For Internal Use Only:

Accepted

ID#: _____

General Information:

If you would like to review the Embryo Donation section of our web site, you may visit-

<http://www.dreamababy.com/embryo-donation.htm>

This form should be used for general information or as a worksheet. **We now ask that each potential embryo donor complete an on-line application which may be found at-**

http://www.dreamababy.com/emb_app_general.php

The information that you provide via the on-line application will be placed into our database system. Once we review your information, we will contact you to discuss the embryo donation process. We will also need to discuss the quality of your embryos with the facility that created them. If we feel we may find a good home for your embryos and after you have signed all required consents, we will then have your embryos shipped to our facility. Once received, we will post some of the information you provided in the application on the web. Potential recipients will then be able to view the information you provided. Your names or any personal information will not be released or posted on the website.

Photograph(s) of a Child (Children):

The **Embryo Recipients** would really appreciate having a baby picture to look at (baby pictures of you, the parents or your offspring) when deciding upon which Donated Embryos to choose. Please do not include any other people in the picture for whom we do not have consent to publish. Providing photos vastly improves the ability of the donated embryos to be matched to the recipients. It is ideal that images be uploaded during the completion of your application, be of good quality and be of reasonable size. Photographs will be accepted but digital images are preferred. Please indicate one of the following:

| Options | Parent(s) Initials & Date |
|---|--|
| We agree to have the enclosed picture(s) anonymously placed on the Embryo Donation section of the practice web site. | _____/_____/_____ _____/_____/_____ |
| We agree to provide a baby picture, but want this only shown anonymously to a Recipient Couple in person. This picture will not be placed on the web site. | _____/_____/_____ _____/_____/_____ |
| We do not want to provide a picture at this time. | _____/_____/_____ _____/_____/_____ |

If you include a picture, please identify who is in the photograph. While names will not be used, we may need to describe the photograph(s) such as "Father as a child," "Mother as a child," "Daughter at six weeks old" or "Son at birth." Photographs can be scanned and returned upon specific request.

The Potential For Future Blood Testing:

Additional laboratory testing may be requested of you by the Embryo Recipients including HIV, Hepatitis and inheritable diseases. This blood testing is purely optional:

| Options | Parent(s) Initials & Date |
|--|--|
| We agree to have our blood re-tested in the future at no expense to ourselves. | _____/_____/_____ _____/_____/_____ |
| We do not agree to have our blood re-tested. | _____/_____/_____ _____/_____/_____ |

The information you provide here will remain confidential. These materials may only be released in their entirety with your written permission.

Much of the information requested below will **not** be seen by any other individuals other than the medical staff of Specialists In Reproductive Medicine & Surgery, P.A, (SRMS). Many of the questions below are quite personal and the answers will **not** be posted on the Embryo Donation web site. Those items shaded will **not** be posted on the web site.

It is understood that some of the embryos were created using donor eggs and donor sperm. If so, please indicate the following (check all that apply):

| Options | Parent(s) Initials & Date |
|--|--|
| <input type="checkbox"/> The embryos were not created using donor eggs or sperm (i.e., only your own eggs and sperm were used). | _____/_____/_____ _____/_____/_____ |
| <input type="checkbox"/> All of the embryos were created using donor eggs. | _____/_____/_____ _____/_____/_____ |
| <input type="checkbox"/> All of the embryos were created using donor sperm. | _____/_____/_____ _____/_____/_____ |
| <input type="checkbox"/> We have a mixture of embryos that were created by both our own eggs/sperm as well as donated eggs/sperm. | _____/_____/_____ _____/_____/_____ |

We appreciate your honesty in answering the questions listed below. Use the back of any of these pages to expand on any issues you feel important. Please **PRINT** or **TYPE** and **CIRCLE** your answers. Please complete all the information requested. Any missing information will require follow-up and delay the acceptance of your embryos in the Embryo Donation Program.

General Contact Information (This information will NOT be placed on the web site):

| | |
|------------------|--|
| Full Name: _____ | |
| Partner: _____ | |
| Address: _____ | |

Donating Parents Identifying Information (cont.)

| | | | | |
|---|--------------|--------------------------------|----------------------------|----------------------------|
| City: _____ | State: _____ | Zip: _____ | | |
| Home Phone: () _____ - _____ | | You may contact me at home: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| Business Phone: () _____ - _____ | | You may contact me at work: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| Cell Phone: () _____ - _____ | | You may contact me via cell: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| Pager: () _____ - _____ | | You may contact me via pager: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| E-Mail: _____ | | You may contact me via e-mail: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| How I found out about the Embryo Donation Program (i.e., SRMS Staff): | | | | |

If the embryos to be donated were **only** created using donor eggs and/or sperm, please include the information you have regarding those donors and do not bother completing all of the sections listed below. Please consider, however, completing the **Optional Essay Section** at the end of this form and sign the form as indicated. Otherwise, please continue to answer the following sections:

| Wife's Physical Characteristics: | | | | | | |
|---|-------------------------------------|---|-----------------------------------|-------------------------------------|-----------------------------------|--------------------------------|
| Date of Birth: ____/____/____ | | Age when embryos frozen: _____ years & _____ months | | | | |
| Ethnic Origin (exp. 50% English, 50% Irish; This is very important!): | | | | | | |
| Race: | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Afro-Amer. | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian | <input type="checkbox"/> Other: | |
| Skin Tone: | <input type="checkbox"/> Fair | <input type="checkbox"/> Medium | <input type="checkbox"/> Olive | <input type="checkbox"/> Light Br. | <input type="checkbox"/> Dark Br. | <input type="checkbox"/> Black |
| Bone Structure: | <input type="checkbox"/> Small | <input type="checkbox"/> Medium | <input type="checkbox"/> Large | | | |
| Eye Color: | <input type="checkbox"/> Blue | <input type="checkbox"/> Blue/Hazel | <input type="checkbox"/> Green | <input type="checkbox"/> Light Br. | <input type="checkbox"/> Dark Br. | <input type="checkbox"/> Black |
| Hair Color: | <input type="checkbox"/> Lt. Br. | <input type="checkbox"/> Med. Br. | <input type="checkbox"/> Drk. Br. | <input type="checkbox"/> Black | <input type="checkbox"/> Other: | |
| | <input type="checkbox"/> Lt. Blonde | <input type="checkbox"/> Med. Bl. | <input type="checkbox"/> Drk. Bl. | <input type="checkbox"/> Straw. Bl. | | |
| | <input type="checkbox"/> Lt. Red | <input type="checkbox"/> Red | <input type="checkbox"/> Red/Br. | <input type="checkbox"/> Auburn | | |
| Hair Texture: | <input type="checkbox"/> Thin | <input type="checkbox"/> Thick | | | | |
| Hair Structure: | <input type="checkbox"/> Straight | <input type="checkbox"/> Curly | <input type="checkbox"/> Frizzy | <input type="checkbox"/> Other: | | |
| Height: | _____ Feet and _____ inches | | | | | |
| Weight: | _____ lbs. | | | | | |

| Husband's Physical Characteristics: | | | | | | |
|---|-------------------------------------|---|-----------------------------------|-------------------------------------|-----------------------------------|--------------------------------|
| Date of Birth: ____/____/____ | | Age when embryos frozen: _____ years & _____ months | | | | |
| Ethnic Origin (exp. 50% English, 50% Irish; This is very important!): | | | | | | |
| Race: | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Afro-Amer. | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian | <input type="checkbox"/> Other: | |
| Skin Tone: | <input type="checkbox"/> Fair | <input type="checkbox"/> Medium | <input type="checkbox"/> Olive | <input type="checkbox"/> Light Br. | <input type="checkbox"/> Dark Br. | <input type="checkbox"/> Black |
| Bone Structure: | <input type="checkbox"/> Small | <input type="checkbox"/> Medium | <input type="checkbox"/> Large | | | |
| Eye Color: | <input type="checkbox"/> Blue | <input type="checkbox"/> Blue/Hazel | <input type="checkbox"/> Green | <input type="checkbox"/> Light Br. | <input type="checkbox"/> Dark Br. | <input type="checkbox"/> Black |
| Hair Color: | <input type="checkbox"/> Lt. Br. | <input type="checkbox"/> Med. Br. | <input type="checkbox"/> Drk. Br. | <input type="checkbox"/> Black | <input type="checkbox"/> Other: | |
| | <input type="checkbox"/> Lt. Blonde | <input type="checkbox"/> Med. Bl. | <input type="checkbox"/> Drk. Bl. | <input type="checkbox"/> Straw. Bl. | | |
| | <input type="checkbox"/> Lt. Red | <input type="checkbox"/> Red | <input type="checkbox"/> Red/Br. | <input type="checkbox"/> Auburn | | |
| Hair Texture: | <input type="checkbox"/> Thin | <input type="checkbox"/> Thick | | | | |
| Hair Structure: | <input type="checkbox"/> Straight | <input type="checkbox"/> Curly | <input type="checkbox"/> Frizzy | <input type="checkbox"/> Other: | | |
| Height: | _____ Feet and _____ inches | | | | | |
| Weight: | _____ lbs. | | | | | |

| Wife's Medical History: | | |
|--------------------------------|----------------------------|--|
| Medical Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |

Donating Parents Identifying Information (cont.)

| | | |
|---|-----------------------------------|---|
| Surgeries: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |
| Current Medications (please include current contraception): | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |
| Allergies: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and they are: |
| Smoker: | <input type="checkbox"/> N | <input type="checkbox"/> Y and how much each day? |
| Alcohol Use: | <input type="checkbox"/> N | <input type="checkbox"/> Y and how much each week? |
| Glasses/contacts: | <input type="checkbox"/> N | <input type="checkbox"/> Y, I need them for <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> All the time |
| Hearing Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y and to what severity? |
| Dental problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y and to what severity? |
| Diet Restrictions: | <input type="checkbox"/> N | <input type="checkbox"/> Y and they are: |
| Blood Type: | <input type="checkbox"/> Not Sure | Blood Type: |
| History of Infertility? | <input type="checkbox"/> N | <input type="checkbox"/> Y, then please describe: |

| | | |
|---|-----------------------------------|---|
| Husband's Medical History: | | |
| Medical Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |
| Surgeries: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |
| Current Medications (please include current contraception): | <input type="checkbox"/> N | <input type="checkbox"/> Yes and of what type: |
| Allergies: | <input type="checkbox"/> N | <input type="checkbox"/> Yes and they are: |
| Smoker: | <input type="checkbox"/> N | <input type="checkbox"/> Y and how much each day? |
| Alcohol Use: | <input type="checkbox"/> N | <input type="checkbox"/> Y and how much each week? |
| Glasses/contacts: | <input type="checkbox"/> N | <input type="checkbox"/> Y, I need them for <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> All the time |
| Hearing Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y and to what severity? |
| Dental problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y and to what severity? |
| Diet Restrictions: | <input type="checkbox"/> N | <input type="checkbox"/> Y and they are: |
| Blood Type: | <input type="checkbox"/> Not Sure | Blood Type: |
| History of Infertility? | <input type="checkbox"/> N | <input type="checkbox"/> Y, then please describe: |

| | |
|---|--|
| Wife's Obstetrical/Gynecologic History: | |
| Total Number of Pregnancies: | |
| Total Number of Term Deliveries (> 37 weeks gestational age): | |
| Total Number of Premature Deliveries (between 20 and 37 weeks gestational age): | |
| Total Number of elective terminations:* | |
| Total Number of spontaneous losses: | |
| Total Number of Living Children: | |

Donating Parents Identifying Information (cont.)

| |
|--|
| Any congenital, developmental or emotional problems with your genetic offspring? |
|--|

* Specific shaded information will **not** be posted on the web.

| Wife's Family History: (Please Include Three generations of your family) | | | |
|---|---|--|-------------------------------------|
| Mother: | <input type="checkbox"/> Alive | Age at death: _____ Cause of Death: | Medical Problems (past or present): |
| Father: | <input type="checkbox"/> Alive | Age at death: _____ Cause of Death: | Medical Problems (past or present): |
| Sisters(s): | <input type="checkbox"/> N | Number of sisters and general health? | |
| Brother(s): | <input type="checkbox"/> N | Number of brothers and general health? | |
| Family History of Genetic Diseases: | Alcoholism: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Blood Diseases: (i.e., hemophilia, thalassemia...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Hearing Difficulties: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Malformations (i.e., cleft lip/palate, heart...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Spinal/Cranial Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Chromosome Abnormalities: (i.e., Down's syndrome...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Color Blindness: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born Blind: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Cystic Fibrosis: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born Deaf: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Diabetes: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Epilepsy: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Glaucoma: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | High Blood Pressure: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Mental Retardation: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Muscular Dystrophy: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Neurofibromatosis: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Premature Degeneration of Any Organ: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Psychiatric Illness: (i.e., Hallucinations, Schizophrenia...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Severe Allergies: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Sickle Cell Disease: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Tay Sach's Disease: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Two or More Miscarriages for Any Family Member: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Other Genetic Diseases: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Explain any "yes" answers here below: | | |

Donating Parents Identifying Information (cont.)

Husband's Family History: (Please Include three generations of your family)

| | | | |
|---------------------------------------|---|--|-------------------------------------|
| Mother: | <input type="checkbox"/> Alive | Age at death: _____ Cause of Death: | Medical Problems (past or present): |
| Father: | <input type="checkbox"/> Alive | Age at death: _____ Cause of Death: | Medical Problems (past or present): |
| Sisters(s): | <input type="checkbox"/> N | Number of sisters and general health? | |
| Brother(s): | <input type="checkbox"/> N | Number of brothers and general health? | |
| Family History of Genetic Diseases: | Alcoholism: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Blood Diseases: (i.e., hemophilia, thalassemia...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Hearing Difficulties: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Malformations (i.e., cleft lip/palate, heart...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born with Spinal/Cranial Problems: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Chromosome Abnormalities: (i.e., Down's syndrome...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Color Blindness: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born Blind: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Cystic Fibrosis: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Born Deaf: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Diabetes: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Epilepsy: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Glaucoma: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | High Blood Pressure: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Mental Retardation: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Muscular Dystrophy: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Neurofibromatosis: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Premature Degeneration of Any Organ: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Psychiatric Illness: (i.e., Hallucinations, Schizophrenia...) | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Severe Allergies: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Sickle Cell Disease: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Tay Sach's Disease: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| | Two or More Miscarriages for Any Family Member: | <input type="checkbox"/> N | <input type="checkbox"/> Y |
| Other Genetic Diseases: | <input type="checkbox"/> N | <input type="checkbox"/> Y | |
| Explain any "yes" answers here below: | | | |

Wife's Social History:

| |
|----------------------|
| Religion: |
| Birth Place: |
| Occupation: |
| Hobbies & Interests: |

| | | | |
|----------------------------------|--|--|--|
| Husband's Social History: | | | |
| Religion: | | | |
| Birth Place: | | | |
| Occupation: | | | |
| Hobbies & Interests: | | | |

| | | | |
|------------------------------------|---|--------------------------------------|---------------------------------------|
| Wife's Educational History: | | | |
| Highest Education Level: | <input type="checkbox"/> Some High School | <input type="checkbox"/> High School | <input type="checkbox"/> Some College |
| | <input type="checkbox"/> College | <input type="checkbox"/> Masters | <input type="checkbox"/> Ph.D. + |
| High School GPA: | Value: | <input type="checkbox"/> Not Certain | |
| College GPA: | Value: | <input type="checkbox"/> Not Certain | |
| SAT/ACT Scores: | Combined score: | <input type="checkbox"/> Not Certain | |
| I.Q. Score: | If Known: | <input type="checkbox"/> Not Certain | |
| Other Educational Comments: | | | |

| | | | |
|---------------------------------------|---|--------------------------------------|---------------------------------------|
| Husband's Educational History: | | | |
| Highest Education Level: | <input type="checkbox"/> Some High School | <input type="checkbox"/> High School | <input type="checkbox"/> Some College |
| | <input type="checkbox"/> College | <input type="checkbox"/> Masters | <input type="checkbox"/> Ph.D. + |
| High School GPA: | Value: | <input type="checkbox"/> Not Certain | |
| College GPA: | Value: | <input type="checkbox"/> Not Certain | |
| SAT/ACT Scores: | Combined score: | <input type="checkbox"/> Not Certain | |
| I.Q. Score: | If Known: | <input type="checkbox"/> Not Certain | |
| Other Educational Comments: | | | |

| |
|--|
| Optional Essay Section: <i>What we want to say to the Recipient of our Donated Embryos.</i> (You may use back of sheet) |
| |

