

PENINSULAR CENTRE FOR REPRODUCTIVE MEDICINE

Preconsultation questionnaire for potential egg or sperm donors

It would be helpful if you could complete and bring this questionnaire/form with you to the first clinic appointment.

If necessary, however, it may be completed in the clinic with the help of clinic staff.

This form is also downloadable from our clinic's website at <http://home2.btconnect.com/pcrm/documents/pcrmdonorq1.2.pdf> and can be completed and either printed or saved electronically. If completed electronically the saved version of the form can be brought with you e.g. on a memory stick or CD, or alternatively we can provide you with an email address to send it to us as an email attachment. (If you wish to use 'encrypted' email we can provide you with our public encryption key).

The first part of the form is information that we need for internal use, including screening purposes. The second part provides the information for the HFEA Form that we would be required to submit to the HFEA if you proceed.

DONOR QUESTIONNAIRE PART 1:

First name(s):

Surname:

Date of birth:

(IF THE DONATION IS NOT TO BE ANONYMOUS, RELATIONSHIP TO RECIPIENTS)

FAMILY HISTORY:

Any illnesses of note affecting your children, if you have any?

Mother: Age Alive? Y/N
If dead, age at death
Cause of death

Father: Age Alive? Y/N
If dead, age at death
Cause of death

Brothers: Age(s) Alive? Y/N
If dead, age at death
Cause of death

Sisters: Age(s) Alive? Y/N
If dead, age at death
Cause of death

Any known hereditary disease in the family Y/N
If Yes, specify

PERSONAL MEDICAL HISTORY

Any current illness: Y/N

Any current long-term medication: Y/N

Any past history of serious illnesses or operation: Y/N

HIV screening questions:-

have either you or your partner to your knowledge

- ever been an intravenous drug abuser or had hepatitis?
- been in prison or had sexual contact with a prostitute within the last 15 years?
- ever lived outside Northern Europe, North America, Australia or New Zealand?
- ever had sexual contact with a homosexual or bisexual?
- had hospital treatment or sexual contact within Africa or Brazil within the last 15 years?
- ever had a sexual partner whom you consider would have answered 'yes' to any of the above questions?

YES / NO

Have you or anyone related directly to you had:

- Epilepsy
- Fits
- Schizophrenia
- Manic depression
- Any other psychiatric disorder
- Any congenital disability, including cleft lip and palate, spina bifida, congenital dislocation of the hip, clubfoot, hypospadias, albinism, neurofibromatosis, tuberous sclerosis, Alport disease, Marfan's syndrome,
- Huntingdon's chorea
- Rheumatoid arthritis
- Hepatitis
- Diabetes occurring when less than aged 50 years
- Hypertension occurring when aged less than 40 years
- Hereditary hypercholesterolaemia
- Thalassaemia
- Sickle Cell Disease
- Haemophilia
- Tay-Sach's disease
- CJD

YES/NO

If yes, state

TRAVEL

- Have you been outside the UK (including business) in the last 12 months?
- Have you ever had malaria or an unexplained fever associated with travel?
- Were you born or have you ever lived or stayed outside the UK for a continuous period of over 6 months or more?
- Have you ever visited Central/South America for a continuous period of 4 weeks or more?
- Have you been or plan to go to an area where West Nile Virus is endemic between and including the months of April and November? This includes: CANADA, UNITED STATES, ITALY, MAINLAND GREECE, ROMANIA, ALBANIA, ISRAEL, TURKEY, FORMER YUGOSLAV REPUBLIC of MACEDONIA and RUSSIA.

YES/NO

If yes, state

Please note that if the information on this form is no longer accurate or you have had an illness or used medication other than that prescribed by our clinic between the time of completion of this form and the time of your treatment you should let us know.

STATEMENT:

I certify that the above information is correct to the best of my knowledge.

Signed:

Date:

Other comments:

Donor Information form



PLEASE WRITE CLEARLY IN
BLACK INK USING BLOCK CAPITALS

Centre:

Form D:

1. What this form is for*

Is registering a new donor: Replaces all details previously registered:

This form replaces form D:

Form completion date:

Donor number: Previous donor number (if changed):

This donor was also registered as patient/partner number:

2. Donor contact details

Current first name(s): Current surname:

First name(s) at birth: (if different from current):

Surname at birth: (if different from current):

Date of birth:

Gender*:

Marital status*: Single Married Cohabit Divorced Widowed

Place of birth:

Country of birth:

NHS Number for UK resident (if known):

OR

Passport/ID Card Number:

Country of issue:

Donor address at date of form completion:

House name or number

Street name

Town

County

Postcode

To be completed by the donor

PLEASE WRITE CLEARLY IN BLACK INK USING BLOCK CAPITALS

Does the donor have their own biological children^x: No Yes

If yes, how many: ^x Girls Boys

Donor's current height (m): ^x Donor's current weight (kgs): ^x

Eye colour*: ^x Blue Brown Green Grey Hazel

Other:

Natural hair colour*: ^x Black Brown dark Brown light
Blonde light Blonde dark Red

Skin colour*: ^x Light/Fair Medium Dark Freckles Olive

*Tick as applicable

In the spaces below please supply a description of your:- ^x

Religion or belief systems:

Occupation:

Interests:

Skills:

Reasons for donating: ^x

About donation

Date gametes produced for use:

Any donations at other centres?* x

No Yes

If yes, last UK or overseas centre for donor (if known) x

Was the donor adopted?* x

No Yes

Was the donor conceived by donation?* x

No Yes

Ethnic group

Please describe your ethnicity if possible:

Donor's own ethnic group

Biological Mother's ethnic group (if known)

Please see form completion manual for current ethnicity codes

Biological Father's ethnic group (if known)

Would the donor like to limit the number of families able to use their donated gametes to fewer than the number specified in the current HFEA guidance?* No Yes x

If yes, please specify

Please note that if egg-sharing you should tick 'No' above

*Tick as applicable

Please list any physical illness or disability, history of mental illness or learning difficulties Please also list any known medical conditions within the donor's biological family. x

Please list below any screening tests carried out for this donor.**

*Tick as applicable

Cystic Fibrosis

HIV

Kryotype

Cytomegalovirus (CMV) antibodies

STDs

Hepatitis B & C

Sickle cell anaemia

Thalassaemia

Tay Sachs

Other:

You may wish to provide in these sections a goodwill message and description of yourself. This information is not compulsory but it is recommended you complete these sections as the information you provide can help parents tell children about their origins and answer some questions a donor-conceived person may have.

Non-identifying information provided in the following sections can, upon request, be shared with patients requiring treatment with donor gametes/embryos, parents of children conceived using your donated gametes/embryos and children conceived using your donated gametes/embryos, once they reach the age of 16. The full content of this form can be made available to donor-conceived people when they reach the age of 18.

I understand that by completing these sections I have consented to the information therein being shared with patients, parents and donor-conceived people, as outlined above.

(Please tick to confirm) x

You may wish to write a goodwill message to be shown to anyone born as a result of your donation.

This page is to be completed by the donor

**PLEASE WRITE CLEARLY IN BLACK INK USING BLOCK CAPITALS
PLEASE COMPLETE ELECTRONICALLY OR HANDWRITE.**

The space below is provided for you to give a description of yourself as a person. The type of information that may be helpful could include your education, achievements, values, and life experiences. Try to imagine yourself as a donor-conceived person, and think about what you might wish to know.

Please continue on additional pages as required (writing the same form number as above on each page)
pcrm donor info F

Donor's signature and
date