Southwest Center for Reproductive Health
Luis S. Noble, M.D., F.A.C.O.G.
700 S. Mesa Hills Dr.
El Paso, TX 79912
(915) 842-9998 * (915) 842-9972

Donor Intake Form

(Please Print)

Donor Name: _____ Age: _____

DOB: _____ SSN: _____

Address: _____

City/State/Zip: _____

Hm Ph#: (____)_____ Cell#: (____)_____ Wk#: (____)_____

Emergency Contact:

Name: _____ Relationship: _____

Hm Ph#: (____)_____ Cell#: (____)_____ Wk#: (____)_____

_____ _____
Donor Signature **Date**

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Luis S. Noble, M.D., F.A.C.O.G.

Dear Doctor:

We are required to have a physician fill out a physical exam form to check for evidence of any possible high risk behaviors or infections with a relevant communicable disease. We would greatly appreciate your help with this process.

Please complete the physical exam request and fax it to our office at (915) 842-9972.

Thank you,

Luis S. Noble, M.D., F.A.C.O.G.
Medical Director
Southwest Center for Reproductive Health

Physical Examination

Patient Name: _____ Date of Birth: _____

		Yes	No
1	Physical evidence for risk of sexually transmitted diseases such as genital ulcerative disease, herpes simplex, syphilis, chancroid	☐	☐
2	**For a male donor**, physical evidence of anal intercourse including perianal condyloma	☐	☐
3	Physical evidence of non-medical percutaneous drug use such as needle tracks, including examination of tattoos, which may be covering needle tracks	☐	☐
4	Physical evidence of recent tattooing, ear piercing, or body piercing	☐	☐
5	Disseminated lymphadenopathy	☐	☐
6	Oral thrush	☐	☐
7	Blue or purple spots consistent with Kaposi's sarcoma	☐	☐
8	Unexplained jaundice, hepatomegaly, or icterus	☐	☐
9	Physical evidence of sepsis, such as unexplained generalized rash	☐	☐
10	Large scab consistent with recent smallpox immunization	☐	☐
11	Eczema vaccinatum	☐	☐
12	Generalized vesicular rash (generalized vaccinia)	☐	☐
13	Severely necrotic lesion consistent with vaccinia necrosum	☐	☐
14	Corneal scarring consistent with vaccinial keratitis	☐	☐

_____ _____

Doctor Signature Date

Southwest Center for Reproductive Health, P.A.
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Retrieval Disclosure and Consent

Medical and Surgical Procedures

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I voluntarily request Dr. Luis S. Noble as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:
Infertility or Oocyte (egg) Donation.

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: **Ultrasound Guided Oocyte (egg) Retrieval.**

I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection with the particular procedure:
Ultrasound Guided Oocyte (egg) Retrieval.

RISKS AS DISCUSSED BY PHYSICIAN:

I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize the anesthesia may have to be changed possibly without explanation to me.

I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage, or even death.

I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

_____	_____
Witness Signature	Witness Printed Name

_____
Luis S. Noble, M.D.

SOUTHWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.
700 S. Mesa Hills Dr.
El Paso, TX 79912
(915) 842-9998 * Fax (915) 842-9972

Luis S. Noble, M.D., F.A.C.O.G.
Lyla M. Wagley, M.S., ELD

Consent Form for Lupron (Leuprolide Acetate)

Gonadotropin Releasing Hormone (GnRh) is a naturally occurring hormone in your body. Lupron is used in conjunction with HMG/FSH in order to induce ovulation for women undergoing IVF. This decreases the incidence of premature ovulation therefore, lowering the cancellation rate for this procedure.

POTENTIAL RISKS

- **May cause cyst formation.**
- **Febrile reaction/cellulitis at the injection site.**

DOSAGE

- **Subcutaneous Lupron: Used for IVF.**

I, _____, have read the information concerning
(Printed Name)

Lupron and understand its indications, potential risks, and side effects.

_____ _____
Patient Signature **Date**

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Luis S. Noble, M.D., F.A.C.O.G.
Lyla M. Wagley, M.S., ELD

Consent Form for Gonadotropin

I voluntarily request that Dr. Luis S. Noble, as my physician and such associates, technical assistants and other health care providers as they may deem necessary, treat my condition which has been explained to me as Infertility.

I, _____, *(patient's printed name)* hereby consent to the administration of FSH (Bravelle, Follistim, Fertinex, Gonal F) and/or HMG (Humegon, Pergonal, Repronex), hCG (Profasi, Novarel) and Lupron to me in the dosage and frequency that his judgment may dictate in order to increase the possibility that I might become pregnant.

I understand that these drugs have known adverse effects such as:

- **Ovarian enlargement.**
- **Visual disturbance.**
- **Multiple pregnancies.**
- **Ovarian hyperstimulation requiring hospitalization.**
- **Twisting or rupture of the ovary necessitating a laparotomy and removal of the ovary and/or blood transfusion.**
- **Water retention and electrolyte imbalance.**
- **Increased coagulability of blood and possible pulmonary embolism or stroke.**
- **Possible association with an increased risk of ovarian cancer.**

I further understand that:

- **Lupron is given to suppress ovarian function by inhibiting pituitary release of gonadotropins and may cause a transient menopausal state, headaches, palpitations, hot flashes, irritability and may profoundly suppress ovarian function.**
- **Any pregnancy may produce an infant with birth defects, but the probability is not increased due to the use of this medication.**
- **The cycle may be canceled in the event of excessive or inadequate ovarian stimulation.**

I have been provided an opportunity to ask questions and such questions have been answered to my satisfaction. I understand I may continue to ask questions relating to this therapy at any time. This form has been fully explained, I have read it or had it read to me, all blanks have been filled in, and I understand its contents.

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**

Southwest Center for Reproductive Health * Luis S. Noble, M.D., F.A.C.O.G.

DONOR RISK FACTOR HISTORY

Please read and answer accordingly. Have you engaged in any of the following activities or had sexual relations with anyone who has engaged in the following activities?

Yes	No	**Risky Behaviors**
☐	☐	Injected drugs for non-medical reasons in the preceding five years, including intravenous, intramuscular, or subcutaneous injections.
☐	☐	Have hemophilia or related clotting disorders that have received human derived clotting factor concentrates, including non-viral inactivated Factor VIII or Factor IX concentrate.
☐	☐	Engaged in sex in exchange for money or drugs in the preceding five years.
☐	☐	Had sex in the preceding 12 months with any person described in the previous three items of this section or with any person known or suspected to have HIV infection, clinically active hepatitis B infection, or hepatitis C infection.
☐	☐	Been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV-infected blood through percutaneous inoculation (e.g., needle stick) or through contact with an open wound, non-intact skin or mucous membrane.
☐	☐	Current inmates of correctional systems (including jails and prisons) and individuals who have been incarcerated for more than 72 consecutive hours during the preceding 12 months.
☐	☐	Had close contact within the preceding 12 months with another person having clinically active viral hepatitis (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly).
☐	☐	Within the preceding 12 months undergone tattooing, ear piercing, or body piercing in which shared instruments are known to have been used.
☐	☐	Are you a xenotransplantation product (transplantation, implantation, or fusion of live cells, tissues or organs from a nonhuman animal source) recipients or intimate contact of a xenotransplantation product recipient.

		Infectious Disease
☐	☐	Had a past diagnosis of clinical, symptomatic viral hepatitis after age 11, unless evidence from the time of illness documents that the hepatitis was identified as hepatitis A (e.g., a reactive IgM anti-HAV test).
☐	☐	Had known or suspected sepsis at this time.
☐	☐	A prior reactive screening test for HIV.
☐	☐	Unexplained weight loss
☐	☐	Unexplained night sweats
☐	☐	Blue or purple spots on or under the skin or mucous membranes typical of Kaposi's sarcoma.
☐	☐	Disseminated lymphadenopathy (swollen lymph nodes) for longer than one month.
☐	☐	Unexplained temperature of greater than 100.5° F (38.6° C) for more than 10 days.
☐	☐	Unexplained persistent cough or shortness of breath.
☐	☐	Opportunistic infections.
☐	☐	Unexplained persistent diarrhea.
☐	☐	Unexplained persistent white spots or unusual blemishes in the mouth.
☐	☐	A prior reactive screening test for hepatitis B virus or hepatitis C virus.
☐	☐	Unexplained jaundice.
☐	☐	Hepatomegaly (enlarged liver).
☐	☐	Have had or have been treated for syphilis or gonorrhea during the 12 months preceding the egg retrieval.
☐	☐	Diagnosis of sepsis (including bacteremia, septicemia, sepsis syndrome, systemic infection or septic shock).
☐	☐	Evidence of infection with unexplained temp. greater than 100.4° F (38° C), elevated heart rate, elevated respiratory rate or elevated white blood cell count.
☐	☐	More severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure).
☐	☐	Positive blood cultures associated with the conditions in the previous question.
☐	☐	Reactive screening test for HTLV.
☐	☐	Unexplained paraparesis (weakness in the lower extremities).
☐	☐	Diagnosis of adult T-cell leukemia.

Date _____ Initials _____

Yes	No	**Infectious Disease cont.**
☐	☐	Could not be tested for HIV infection because of refusal, inadequate blood samples, or any other reason.
☐	☐	Had repeatedly reactive screening assay for HIV-1, HIV-2, Hepatitis C or HTLV-1 antibody and Hepatitis B.
☐	☐	History, physical exam and medical records reveal other evidence of HIV infection or high-risk behavior such as diagnosis of AIDS, sexually transmitted diseases or needle tracks or other signs of parenteral drug abuse.
☐	☐	History, physical exam and medical records reveal other evidence of Hepatitis B or Hepatitis C infection, such as diagnosis of Hepatitis B or Hepatitis C, unexplained yellow jaundice, AST and bilirubin or prothrombin time.

		West Nile Virus
☐	☐	Had a medical diagnosis of West Nile Virus (WNV) infection (including diagnosis based on symptoms and laboratory results, or confirmed WNV viremia in the preceding 28 days.
☐	☐	Had both a fever and a headache (simultaneously) during the preceding 7 days.

		SARS
☐	☐	Suspected to have SARS or who are known to have SARS or treatment for SARS within the preceding 28 days.
☐	☐	Had close contact the preceding 14 days with persons with SARS or suspected SARS.
☐	☐	Traveled to or resided in areas affected by SARS within the preceding 14 days.
☐	☐	Have you been exposed or suspect exposure to SARS? **If you answered YES to the previous question, complete the following:**
☐	☐	Had a moderate respiratory illness with a temp of greater than 100.4° F (38° C) and lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing or hypoxia (low concentration of oxygen).
☐	☐	Had severe respiratory illness with a temp. of greater than 100.4° F (38° C) and lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing or hypoxia) and radiographic evidence of pneumonia or respiratory distress syndrome.
☐	☐	Lymphopenia (low lymphocyte count) with normal or low white blood cell count.
☐	☐	Elevated hepatic transaminases (liver enzymes).
☐	☐	Elevated creatine phosphokinase.
☐	☐	Elevated lactate dehydrogenase.
☐	☐	Elevated C-reactive protein.
☐	☐	Prolonged activated partial thromboplastin time.

		Smallpox
☐	☐	Smallpox vaccination in the 12 months preceding the egg retrieval.
☐	☐	Eczema vaccination (complication of a smallpox vaccination if a person has eczema).
☐	☐	Acquired a clinically recognizable vaccinia virus infection (scab or skin lesions) by close contact with someone who received the smallpox vaccine in the preceding three months.
☐	☐	Vesicular rash (small blisters) following a smallpox immunization of following close contact (e.g., living in the same household where sharing of kitchen and bathroom facilities occurs regularly) with someone who recently had a smallpox immunization.
☐	☐	Progressive necrosis (dying skin tissue) in the area of a smallpox vaccination.
☐	☐	Encephalitis following smallpox vaccination.
☐	☐	Vaccinial keratitis (infection of the cornea of the eye following smallpox vaccination).
☐	☐	Fever, headache, body aches, or eye pain accompanied by skin rash on the trunk of the body.
☐	☐	Fever, headache, body aches, or eye pain accompanied by swollen lymph glands.
☐	☐	Severe illness diagnosed as encephalitis, meningitis, meningoencephalitis, or acute flaccid paralysis.
☐	☐	Symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions and muscle weakness or paralysis.

Date _____ Initials _____

Southwest Center for Reproductive Health, P.A.

DONOR RISK FACTOR HISTORY

1. **Are you presently taking any prescribed medication?** **YES** ◯ **NO** ◯
   If YES, please specify what and why: _____
2. **Did you take any prescribed medications within the last six weeks?** **YES** ◯ **NO** ◯
   If YES, please specify what and why: _____
3. **Have you ever used marijuana or other illegal drugs?** **YES** ◯ **NO** ◯
   If YES, what, when and how often? _____
4. **Do you smoke cigarettes?** **YES** ◯ **NO** ◯
5. **Have you ever had or been treated for any form of STD, including syphilis, or gonorrhea?** **YES** ◯ **NO** ◯
6. **Did you exhibit any of the following conditions within the preceding 12 months?**
   Dysuria (painful urination) **YES** ◯ **NO** ◯
   Urethral Discharge **YES** ◯ **NO** ◯
   Genital Ulcer **YES** ◯ **NO** ◯
7. **In the preceding six months, did you have a sexual partner who had a Trichomonas infection?** **YES** ◯ **NO** ◯
8. **Have you ever experienced any of the following conditions?**
   Genital herpes **YES** ◯ **NO** ◯ If YES, list date: _____
   Genital warts **YES** ◯ **NO** ◯ If YES, list date: _____
   Hepatitis **YES** ◯ **NO** ◯ If YES, list date: _____
9. **In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing a kitchen and bathroom facilities occurred regularly) with anyone who has had:**
   Genital herpes **YES** ◯ **NO** ◯
   Genital warts **YES** ◯ **NO** ◯
   Chronic Hepatitis (carrier) **YES** ◯ **NO** ◯
10. **Do you have any tattoos?** **YES** ◯ **NO** ◯ If YES, list date received: _____
11. **Have you ever had acupuncture/ear piercing/body piercing?** **YES** ◯ **NO** ◯
    If YES, identify type and list date(s): _____
12. **Have you ever been previously excluded from blood donation?** **YES** ◯ **NO** ◯
    If YES, identify the reason and date(s): _____
13. **Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)?** **YES** ◯ **NO** ◯
    If YES, explain: _____
14. **Did you have a blood transfusion in the preceding 12 months?** **YES** ◯ **NO** ◯
    If YES, explain: _____
15. **Were you bitten by an animal suspected of rabies in the preceding 12 months?** **YES** ◯ **NO** ◯
    If YES, explain: _____
16. **Have you been diagnosed with Creutzfeldt-Jakob disease or do you have any blood relatives with non-iatrogenic Creutzfeldt-Jakob disease?** **YES** ◯ **NO** ◯
    If YES, explain: _____
17. **Do you have any history of dementia or degenerative neurological disorders of viral or unknown etiology?** **YES** ◯ **NO** ◯ If YES, please explain: _____

Date _____ Initials _____

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El Paso, TX 79912

DONOR RISK FACTOR HISTORY

I certify that the above information is, to the best of my knowledge, true and complete, and I have not intentionally omitted/withheld any information required to be given in this questionnaire. I also acknowledge that I have asked the meaning of any term that I was not familiar with.

_____ _____
Signature of Donor Date

_____
Printed Donor Name