Known Gestational Carrier Checklist

We compiled a checklist of requirements that must be met when using a Gestational Carrier. A Program Start will be scheduled upon completion of the following:

For Intended Parents:

- There are two FDA required questionnaires to be filled out by both Intended Parents. You will be provided with a link and instructions to access these questionnaires online. These must be updated every six months for as long as you are in treatment.

- Both Intended Parents must complete FDA required lab work and physical exams. The physical must be completed within 7 days of the lab work. This is often completed in one office visit.

    - Labs and physicals can be provided off-site at an FDA approved lab, or Memorial Blood Center. Special arrangements will be coordinated by an RMIA staff member.

    - Males must also complete a semen cryopreservation within seven days of labs and physical. This is done on-site at RMIA and $400 is due at the time the services are rendered.

- Two psychological evaluations are required. The first visit will include only the Intended Parents. The second visit will include both Intended Parents and the Gestational Carrier. If marriage applies, her spouse is also required to attend the joint session. Referrals will be given by an RMIA staff member.

- (Females Only) Remember to call on the 1st day of your period and start birth control on the 3rd day.

For Gestational Carrier:

- You will receive a New Patient packet via email, which will include the registration form, the 14 page questionnaire, and HIPAA consent forms. Please complete and email back to RMIA.

- Complete FDA required lab work. If marriage applies, your spouse is also required to complete labs.

- Two psychological evaluations are required. The first visit will include only the Gestational Carrier and her spouse, if married. The second visit will include both Intended Parents and the Gestational Carrier and her spouse if marriage applies. Referrals will be given by an RMIA staff member.

- Remember to call on the 1st day of your period and start birth control on the 3rd day.

- You will be scheduled to meet with the doctor to sign consents.

Reproductive Medicine & Infertility Associates

REGISTRATION FORM FOR GESTATIONAL CARRIERS

FEMALE
Legal Name: _____
Address: _____
_____
Phone 1 _____ H / W / C
Phone 2 _____ H / W / C
Date of birth: _____ Age: _____

PARTNER (F / M) □ Married □ Non-Married
Legal Name: _____
Date of birth: _____

Intended Parent(s): _____

Is it OK to communicate via email? If so, email address: _____
Email address of the agency contact person (if applicable): _____

Do you have any flu-like symptoms (cough, fever, shortness of breath)? Y / N
Have you been in close contact with someone who has been diagnosed less than 14 days ago? Y / N
Have you been tested for COVID-19 and are awaiting results? Y / N
Have you been recommended to self quarantine? Y / N

OB/GYN clinic and physician (***REQUIRED***):

Clinic Name: _____ Physician name: _____

Location: _____

1. Height: _____ Weight: _____BMI: _____
2. Have you ever been a gestational carrier in the past? Yes / No
3. Have you ever been pregnant? Yes / No *If yes, outcome*: ____# Live birth
   ____# Miscarriage/abortion
4. Have you had any C-sections or other surgeries involving the uterus? Yes / No

   _____

   If "Yes" any complications? _____
   Lower transverse cesarean section (horizontal incision) _____
   or Classic cesarean section (vertical incision) _____
   □ ***Obtain operative report(s)***
5. Any medical conditions?_____
   _____

   _____
6. Current medications _____
7. Latex allergy: Yes / No
8. Needle phobia: Yes / No
9. Currently on any form of birth control? If so, what type? _____
10. Breast feeding: Yes / No

<u>If prospective gestational carrier had c-section or abdominal surgery, obtain following before routing to MD for review:</u>
□ *Operative report(s)* □ *Intended parents chart*
□ *This completed form*

<u>If no previous cesarean section deliveries, route this form with intended parents chart to MD for review.</u>
□ *Intended parents chart*
□ *This completed form*

MD to complete:
□ Sono/TT first
□ Prescreen for Program Start

Prospective Donor's Initials: _____

Reproductive Medicine & Infertility Associates

DONOR APPLICATION & MEDICAL/GENETIC HISTORY

**Please complete form using black or blue ink. Do not use white-out.*
If you wish to change something, just cross through it with a single line.

To: Prospective Gamete (egg or sperm) Donor or Gestational Carrier (G.C.)

All prospective gamete donors (including anonymous egg donors, known egg donors, egg share participants, and both members of a couple using a gestational carrier) and gestational carriers must complete this application and medical/genetic history questionnaire. It is important that you answer each and every question to the best of your ability. Leave no question unanswered. We thank you for your honesty in supporting our efforts to maintain a safe donor population for our community.

The undersigned agrees that, to the best of her/his knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our clinic any significant changes in the status of her/his health, especially in regards to sexually transmitted disease and to notify the clinic of any new acupuncture treatments, electrolysis treatments, ear or body piercing or tattooing that occur(s) after completion of this form.

_____

Donor/G.C. Applicant Name (Printed) Donor/G.C. Applicant Signature Date

If you are married or have a significant other/regular sexual partner, please provide the following information for that person:

_____

Printed Full Name (First, M.I., Last) Date of Birth

Check the category that applies to you: ☐ Anonymous egg donor ☐ Known egg donor ☐ Egg share participant

☐ Intended parent (female) ☐ Intended parent (male) ☐ Gestational carrier

If you are a known egg donor, please provide the name of your recipient; if you are an intended parent, please provide the name of your gestational carrier; and if you are a gestational carrier, please provide the name(s) of your intended parents. _____

.....

Donor Application Number (Clinic will complete):_____

☐ **OK to proceed/ fwd to Gen.**
☐ **Not acceptable**

_____ _____
Signature of RMIA Physician Doing Initial Review (if required) **Date**

☐ **OK to proceed**
☐ **Not acceptable**

_____ _____
Signature of RMIA Physician Doing Final Review **Date**

_____
Signature of RMIA Staff Member who Reviewed Form for Completeness **Date**

INSTRUCTIONS: Please print all of the requested information. Write "NA" in blanks that are not applicable. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships, such as "first cousin through my mother's sister." Please provide information on all relatives requested. You do not need to list names. If you have questions, please contact the clinic at 651-222-6050 or 1-800-440-7359.

PERSONAL INFORMATION Date: ________________________

Name: ____

Street Address: ____

City: ________________________________ State: ___________________ Zip: ______________

Phone(s): (_____)______________________ (_____)______________________ (_____)______________________
Home Cell Work

Email: ____

Messages should be left at: ____________________________________ Date of Birth: ________________________ Age: __________

Place of Birth: ____ Social Security Number: _______________________________

- - - -**GESTATIONAL CARRIERS AND INTENDED PARENTS MAY SKIP TO QUESTIONS AFTER NEXT DOTTED LINE**- - - - -

Are you adopted? ☐ Yes ☐ No

Race: ☐ Native American ☐ Black, Non-Hispanic ☐ White, Non-Hispanic ☐ Latina /Hispanic
☐ Asian/Pacific Islander ☐ East Indian ☐ Multi Race

Country/Countries of Ancestors' Origins: ____

Religion: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Islam ☐ Other (Specify):______________________

Natural Hair color: ☐ Black ☐ Dark Brown ☐ Brown ☐ Light Brown ☐ Blonde ☐ Auburn ☐ Red

Hair texture: ☐ Straight ☐ Wavy ☐ Curly ☐ Kinky ~ Baldness: ☐ Yes ☐ No Baldness in Family: ☐ Yes ☐ No

Eye color: ☐ Blue ☐ Brown ☐ Hazel ☐ Green ☐ Blue-Green ☐ Blue-Grey ☐ Black

Bone size: ☐ Small ☐ Small-Medium ☐ Medium ☐ Medium-Large ☐ Large

Complexion: ☐ Very Fair ☐ Fair ☐ Medium ☐ Olive ☐ Dark

Current Occupation: ____

Highest Degree earned: ☐ High School ☐ Vo-Tech ☐ AA ☐ Bachelors ☐ Masters ☐ Doctorate

Specify Degrees: ____

Current hobbies and interests: ____

- -

Height: __________ inches Weight: __________ pounds

Blood type (if known): ☐ A ☐ B ☐ AB ☐ O Rh: ☐ Positive ☐ Negative

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

How many children do you have? __________

Have you ever been convicted of a crime: ☐ Yes ☐ No
If yes, for what crime: ____
If yes, did you spend any time in jail/prison: ☐ Yes ☐ No Length of time: ________________________

DONOR RISK FACTOR HISTORY

Please circle either Yes or No; and if Yes, please explain if requested.

1. Are you presently taking any prescribed medications? Yes No
   If yes, please specify what and why: _____

2. Have you taken any prescribed medications (other than noted in #1) within the last six weeks? Yes No
   If yes, please specify what and why: _____

3. Have you ever used marijuana or other illegal drugs (e.g., LSD, cocaine, heroin, ecstasy, etc.)? Yes No
   If yes, what, when and how often? _____

4. Do you smoke cigarettes? Yes No If yes, for how long? _____ How many cigarettes daily? _____

5. Have you ever had or been treated for any form of sexually transmitted disease, including syphilis, gonorrhea or chlamydia?
   Yes No If yes, specify: _____

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 of 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. In the preceding 12 months, have you undergone tattooing? Yes No If yes, list date _____

11. In the preceding 12 months, have you had acupuncture/ear piercing/body piercing/electrolysis? 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. Have you had 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, when:_____ 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 neurologic disorders of viral or unknown etiology? Yes No
    If yes, explain _____

18. Have you received a transplant of human dura mater? Yes No
If yes, explain _____

19. Have you been diagnosed with West Nile Virus, encephalitis or meningitis of viral or unknown cause? Yes No
If yes, explain _____

20. Did you have a vaccination or immunization in the preceding 12 months? Yes No
If yes, explain _____

21. In the preceding 12 months, did you have sex or close contact with someone who received the smallpox vaccine? Yes No
If yes, explain _____

PERSONAL MEDICAL HISTORY

Allergies (medicines, food, pollen, etc)? Yes No

If yes, please list substance and reaction caused: _____

List any childhood allergies that you have outgrown: _____

Do you have normal hearing? Yes No

If no, please explain: _____

Do you wear contacts or glasses or have you had any corrective eye surgery (e.g. Lasik, etc.)? Yes No

Have you or any of your sisters, brothers or parents required braces or any other significant orthodontic work? Yes No

If yes, please explain: _____

Have any of your relatives had cosmetic dentistry? Yes No

If yes, please explain: _____

Were you born with any birth defects (i.e., heart defect, cleft lip or palate, club feet, etc.)? Yes No

If yes, please explain: _____

Have you had any (major or minor) operations/surgical procedures: Yes No

If yes, please complete: Year Type of Operation/Surgical Procedure

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized other than for surgery? Yes No

If yes, please complete: Year Type of Illness

_____ _____
_____ _____
_____ _____

Have you ever had any broken bones? Yes No

If yes, please explain:_____

Have you ever had any serious illness? Yes No
If yes, please explain:_____

How many days in the preceding 12 months could you not work because of illness, etc. (colds, flu, accidents, surgery, etc)? _____

Are you currently under a physician's care for any reason? Yes No

If yes, please explain:_____

Do you have any health problems that were not covered in the previous questions? Yes No

If yes, please explain: _____

List all current medications (include prescription, nonprescription, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List <u>all</u> drugs you have taken in the preceding 12 months that were not listed above (including recreational drugs)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been treated for any form of cancer? Yes No
If yes, please explain (include cancer diagnosis and type of treatment): _____

Have you ever had or been treated for syphilis? Yes No
If yes, when: _____ How many times? _____ When was the last time? _____

Have you ever had or been treated for gonorrhea? Yes No
If yes, when: _____ How many times? _____ When was the last time? _____

Have you been tested for HIV (AIDS)? Yes No
If yes, when: _____ Reason for testing: _____

Have you ever known or associated with anyone who has told you that they had a positive HIV (AIDS virus) test? Yes No

If yes, please explain: _____

Are you now or have you ever had homosexual experiences or intercourse with a homosexual/bisexual male? Yes No

Have you ever had any intravenous (IV) infusions of blood or have you ever given yourself or had anyone give you IV injections for any purpose? Yes No

If yes, please explain: _____

Do you take or have you ever taken any concentrated products derived from blood or blood substances? Yes No

Have you or any of your sexual partners ever had:

NSU (non specific urethritis)	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Chlamydia	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Venereal warts	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Herpes	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Other sexually Transmissible diseases	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____

How many sexual partners have you had sexual activity with in the last: Week _____ Month _____ Year _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.) Yes No

If yes, please explain: _____

Did you travel outside the United States (except Canada) in the preceding three years? Yes No

If yes, when and where? _____

If yes, did you contract any disease(s) from your foreign travel? Yes No

If yes, please list disease(s): _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.) Yes No

Which substance(s)? _____

If yes, when: _____ Where? _____

Have you ever used or do you currently use any of the following drugs?

Marijuana	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Cocaine	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Barbiturates	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Narcotics/Opiates (Heroin, Methadone, Opium, Morphine, Codeine)	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Amphetamines	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Hallucinogens	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Tranquilizers	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
PCP	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Inhalants	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Steroids	Yes	No	If yes, Frequency/Year(s)_____	How Used_____

Do you drink alcoholic beverages: Yes No
If yes, which kinds? _____Beer _____Wine _____Liquor
Approximately how many drinks per day or week do you consume?_____
If you drink less than 3 drinks per day, was there ever a time when you drank more? Yes No
If yes, how much_____ When (give years)_____

Have you ever been in an alcohol or substance abuse program? Yes No

Do you have any relatives with alcoholism? Yes No
If yes, who?_____

Do you use tobacco products? Yes No
If cigarettes, how many packs a day? _____How long have you been smoking regularly?_____
Other tobacco products? _____
If you did smoke but quit, when did you last smoke?_____

Have you been or are you exposed to any EXCESSIVE amounts of the following in your work environment, living environment or while involved in hobbies? Please consider carefully.

Exposed to	Yes/No	When	How Often
Toxic chemicals, solvents or their fumes	Yes No		
Radiation (x-rays or radioisotopes)	Yes No		
Chemotherapeutics	Yes No		

- - - - - - - - - - -FEMALES ONLY, MALES MAY SKIP TO GENERAL MEDICAL HISTORY/REVIEW OF SYSTEMS- - - - - - - - - - -

Gynecologic History:

Age at onset of menses _____

# of days from beginning of one cycle to the beginning of the next (naturally, not on birth control): Average:_____ Range: _____

Length (# of days) of menstrual flow: _____ Amount of flow (please circle): Light Moderate Heavy

First day (date) of last menstrual period: _____ First day (date) of previous menstrual period: _____

Describe any menstrual problems: _____

Describe any vaginal discharge or irritation: _____

Most Recent Pap Smear: _____ Have you ever had an abnormal Pap smear? Yes No
If yes, have your subsequent Pap smears been normal? Yes No

Describe any difficulty with intercourse: _____

Do you have problems with pelvic pain, infections, endometriosis, etc? _____

Have you ever been treated for infertility? Yes No

Contraceptive History:

Currently use: _____IUD _____Diaphragm _____Condom _____Birth Control Pills _____Birth Control Patch

_____Rhythm _____Spermicide _____Depo-Provera _____Permanent Sterilization (e.g. tubal ligation)

If Birth Control Pills/Patch, how long have you been taking/using them? _____

Why did you start taking/using them? _____

If Depo-Provera when was your last injection? _____

Pregnancy History:

Total #: Pregnancies (confirmed) _____ Living Children _____ Full-term _____ Premature _____

Stillborn _____ Miscarriages _____ Ectopics _____ Elective Abortions_____

Length of time it took you to get pregnant. Shortest_____ Longest_____

Pregnancy/Delivery Complications: _____

Egg Donation History (not applicable to gestational carriers)

Have you applied or been screened to be an egg donor before? _____Yes _____No

If yes, list name and location of egg donor program(s): _____

_____

_____

Were you accepted as an egg donor? _____ Yes _____ No If yes, how many times did you cycle? _____

Are you currently enrolled as an egg donor in another program?_____Yes _____No

---

General Medical History/Review of Systems

Please indicate with a check mark (T) whether you currently have, have had in the past, or have ever been treated for:

Yes	No		Yes	No	
_____	____	blood transfusion	_____	____	cancer
_____	____	kidney stones	_____	____	high blood pressure (hypertension)
_____	____	urinary tract infection	_____	____	diabetes
_____	____	renal (kidney)disease	_____	____	tendency to bleed or bruise easily
_____	____	psychiatric disorders	_____	____	neurological disorder
_____	____	heart problems	_____	____	headaches, dizziness
_____	____	eye problems	_____	____	ear infection or problems
_____	____	skin infections or disease	_____	____	nose, throat or mouth problems
_____	____	breast lumps or discharge	_____	____	chest problems (e.g., pneumonia, cough, infections)
_____	____	bone or joint problems	_____	____	back problems
_____	____	gastrointestinal problems	_____	____	recent unexplained weight gain or loss
_____	____	Tb or exposure to Tb	_____	____	blood clots

If yes for any of the above, please explain:_____

_____

_____

_____

_____

_____

DONOR GENETIC HISTORY (intended parents and gestational carriers do not need to complete)

Were you born with any birth defects (heart defect, cleft lip or palate, club feet, other)? Yes No
If yes, explain:_____

Are there any known genetic conditions or birth defects in your family? Yes No
If yes, explain:_____

Are you of Jewish ancestry? Yes No Unknown

If yes, please check: _____ Ashkenazi _____ Sephardic _____ Other

Have you been tested as a carrier for any of the following diseases:			If yes, result(s)		
Tay-Sachs disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Gaucher's disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Canavan disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Fanconi anemia, group C:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Niemann-Pick disease, type A:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Mucolipidosis, type IV:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Familial dysautonomia:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Bloom syndrome:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Cystic fibrosis	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Glycogen storage disease 1A	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Maple syrup urine disease	Yes	No	_____ carrier	_____ not a carrier	_____ unknown

Are you of black or Mexican/Latin American ancestry? Yes No Unknown
If yes, have you been tested as a carrier of sickle cell disease? Yes No Unknown
If yes, result: _____carrier _____not carrier _____unknown

Are you of Mediterranean, Latin American, Chinese or Southeast Asian ancestry? Yes No Unknown
If yes, have you been tested as a carrier of thalassemia? Yes No
If yes, result: _____carrier _____not carrier _____unknown

Are you of white ancestry? Yes No Unknown
If yes, have you been tested as a carrier of cystic fibrosis? Yes No Unknown
If yes, result: _____carrier _____not carrier _____unknown

Are you a twin, triplet, etc? Yes No

Is there a history of multiple births in your family? Yes No

Genetic History Questionnaire (intended parents and gestational carriers do not need to complete)

The following questions apply to yourself and your family members, whether living or dead, including your children; your parents, your sisters and brothers (also half-sisters and half-brothers), your nieces and nephews, your mother's sisters, brothers and parents, your father's sisters, brothers and parents and your cousins.

Do you have any of the following? Please check either YES or NO for each question. For each question to which you answer YES, please give a more detailed explanation in the area (on page 11 of 13) following the questions.

	YES	NO	
1.	----------		Any relatives with any of the common disorders, listed below, that were diagnosed earlier in life than typical? These common disorders and early ages of onset for each of them are:
a.	☐	☐	Heart disease before age 50?
b.	☐	☐	Vision loss before age 55?
c.	☐	☐	Hearing loss before age 60?
d.	☐	☐	Dementia (such as Alzheimer's disease) before age 60?
e.	☐	☐	Breast cancer before age 50?

f. ☐ ☐ Colon cancer before age 50?
g. ☐ ☐ Prostate cancer before age 60?

2. ☐ ☐ Any relatives that died as infants or in childhood?

3. ☐ ☐ Any relatives that died at an early age (before 50)?

4. ☐ ☐ Any closely related individuals in your family that have the same condition, especially if the condition is rare?

5. ☐ ☐ Any relatives that have experienced 3 or more pregnancy losses (e.g., miscarriages, stillbirths)? Any babies with birth defects detected before birth (by ultrasound) or that were miscarried? Any relatives that have had a stillborn baby with or without birth defects?

6. ☐ ☐ Any relatives with bilateral (both sides) disease in paired organs, such as kidneys, breasts, ovaries, lungs, etc?

7. ☐ ☐ Any relative(s) who had a sudden cardiac death even though they seemed previously healthy?

8. ☐ ☐ Any relative(s) with diagnosed mental illnesses such as bipolar disease (manic-depressive disorder), schizophrenia or depression?

9. ☐ ☐ Any relative(s) in consanguineous (first cousins or more closely related) relationships who have children with medical problems or birth defects?

10. ---------- Any relatives with:
a. ☐ ☐ Two or more medical conditions (e.g., diabetes and muscle disease or hearing loss and kidney disease)?
b. ☐ ☐ A medical condition and dysmorphic (malformed or different looking) features?
c. ☐ ☐ Developmental delay with dysmorphic features and/or physical birth anomalies?
d. ☐ ☐ Developmental delay with or without other medical conditions?
e. ☐ ☐ Severe learning disabilities?
f. ☐ ☐ Mental retardation?
g. ☐ ☐ Autism?
h. ☐ ☐ Progressive mental retardation or loss of achieved developmental milestones?
i. ☐ ☐ Unexplained hypotonia (low/poor muscle tone)?
j. ☐ ☐ A movement disorder (like Parkinson's disease)?
k ☐ ☐ Unexplained seizures?
l. ☐ ☐ Unexplained ataxia (unbalanced gait or walk)?
m. ☐ ☐ Two or more major birth defects (e.g. neural tube defect, congenital heart defect, etc.)?
n. ☐ ☐ Three or more minor birth anomalies (extra or missing fingers and/or toes, etc.)?
o. ☐ ☐ Cleft palate or cleft lip with or without cleft palate?
p. ☐ ☐ One major birth defect with two minor birth anomalies?
q. ☐ ☐ Unusual birthmarks, particularly if associated with learning disabilities, seizures or dysmorphic features?
r. ☐ ☐ Hair anomalies, such as sparse, brittle, coarse or absent hair?
s. ☐ ☐ Congenital (from birth) or juvenile deafness?
t. ☐ ☐ Congenital or juvenile blindness?
u. ☐ ☐ Cataracts at a young age?
v. ☐ ☐ Ambiguous genitalia (genitals that are difficult to classify as male or female)?
w. ☐ ☐ Proportionate short stature with dysmorphic features and/or delayed or arrested puberty?
x. ☐ ☐ Disproportionate short stature?
y. ☐ ☐ A history of infertility?

11. ---------- Any female relatives with:
a. ☐ ☐ Primary amenorrhea (no menstrual period before age 16)?
b. ☐ ☐ Premature ovarian failure (menopause before age of 35), with or without a family history of individuals, in particular males, with mental retardation?
c. ☐ ☐ Proportionate short stature and primary amenorrhea?
d. ☐ ☐ Ovarian cancer, particularly if premenopausal at diagnosis and with bilateral involvement?

12. ---------- Any male relatives with:
a. ☐ ☐ Hypogonadism (small genitalia) and/or significant gynecomastia (breast development)?
b. ☐ ☐ Breast cancer?
c. ☐ ☐ Congenital absence of the vas deferens?
d. ☐ ☐ Oligozoospermia (low sperm count) or azoospermia (no sperm)?

	Num.	CONDITION	YES	NO		Num.	CONDITION	YES	NO
	13	Adrenal dysfunction				43	Hunter's syndrome		
	14	Albinism				44	Huntington's chorea		
	15	Alcoholism				45	Hypospadias		
	16	Allergies				46	Kidney disease/disorders/cancer		
	17	Alzheimer's disease				47	Lesch-Nyhan syndrome		
	18	Asthma				48	Leukemia		
	19	Blindness or significant vision loss				49	Liver cancer		
	20	Breast cancer				50	Marfan syndrome		
	21	Canavan's disease				51	Muscular dystrophy		
	22	Cataracts before age 50				52	Neurofibromatosis		
	23	Club feet				53	Phenylketonuria		
	24	Colon disease				54	Pigmentation disorder		
	25	Color blindness				55	Premature menopause		
	26	Congenital heart defect				56	Prostate cancer		
	27	Congenital hip problems				57	Pyloric stenosis		
	28	Crohn's disease				58	Retinitis pigmentosa		
	29	Cystic fibrosis				59	Seizures		
	30	Deformity of the ear				60	Sickle-cell anemia		
	31	Diabetes mellitus				61	Skin cancer		
	32	Drug abuse or addiction				62	Spina bifida		
	33	Endometriosis				63	Stroke		
	34	Epilepsy				64	Tay Sachs		
	35	Fragile X				65	Thalassemia		
	36	Gaucher's disease				66	Thyroid disease/cancer		
	37	Goiter				67	Turner syndrome		
	38	Hemophilia				68	Ulcerative colitis		
	39	Hermaphroditism				69	Uterine cancer		
	40	High blood pressure (hypertension)				70	Uterine fibroids		
	41	High cholesterol/lipids				71	Wilson's disease		
	42	Hirschsprung's disease				72	Any cancer not already noted		

If you answered YES to any of the questions in this Genetic History Questionnaire section, in the area below please indicate the question number (and letter, e.g. 12a, if applicable), the relative(s) to whom the question applies and provide explanatory comments. If more room is needed, please continue on the reverse side of page 13.

Question Number	Relative(s) to Whom Question Applies	Explanatory Comments

Please check this box ☐ if more room was needed and information is continued on reverse side of page 13.

MOTHER'S FAMILY HISTORY

Relative	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed
Grandfather						
Grandmother						
Aunt						
Aunt						
Aunt						
Aunt						
Uncle						
Uncle						
Uncle						
Uncle						
Mother						

Include stillborns, infant deaths, and childhood deaths. Also indicate on a separate page if any of your cousins has any major medical problems, birth defects, developmental delay or other listed problems. Also indicate which aunt or uncle is their parent.

FATHER'S FAMILY HISTORY

Relative	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed
Grandfather						
Grandmother						
Aunt						
Aunt						
Aunt						
Aunt						
Uncle						
Uncle						
Uncle						
Uncle						
Father						

Include stillborns, infant deaths, and childhood deaths. Also indicate on a separate page if any of your cousins has any major medical problems, birth defects, developmental delay or other listed problems. Also indicate which aunt or uncle is their parent.

SIBLING HISTORY

Sex	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed

CHILDREN'S HISTORY

Sex	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed

Why do you want to be an egg donor (to be answered by anonymous egg donors only)?

_____

_____

_____

_____

_____

_____

Zika Virus Addendum Questions

Donor Name: _____ Donor Number: _____

1. Have you ever been diagnosed with a Zika virus infection in the past 6 months? _____Yes _____No

2. Have you resided in, or traveled to, an area with active Zika virus transmission within the past 6 months? _____Yes _____No (Refer to http://www.cdc.gov/zika/geo/active-countries.html)

3. Have you had sexual intercourse within the past 6 months with a male who is known to have either been diagnosed with the Zika Virus or has resided or traveled to an area with active Zika virus transmission within the past 6 month? _____Yes _____No

Questions Reviewed by: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in RMIA's Notice of Privacy Practices. RMIA is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of RMIA's Notice of Privacy Practices.

Patient Printed Name: _____ Patient Chart #: _____

Patient Signature: _____ Date: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Patient Representative Signature: _____ Date: _____

ENTITY USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

_____

Signature: _____ Date: _____

Reproductive Medicine & Infertility Associates

CONTACT PREFERENCE & HIPAA CONSENT TO LEAVE MESSAGES

Reproductive Medicine & Infertility Associates (RMIA) gives patients the option to choose a preferred method in which to communicate medical information. Please choose **one** of the options below:

- ☐ Cell: _____
- ☐ Home: _____
- ☐ Work: _____
- ☐ Partner Cell: _____

☐ I give RMIA permission to leave messages regarding my medical care and treatment at the number provided above.

☐ I do NOT give RMIA permission to leave messages regarding my medical care and treatment at the number provided above. RMIA will only leave a message asking me to return the call.

I understand that RMIA will be communicating medical information regarding my care and treatment with RMIA by using the selected method above, and may leave a message, unless otherwise notified by myself or RMIA.

_____	_____
Patient Printed Name	Patient ID#
_____	_____
Patient Signature	Date
_____	_____
Partner Printed Name	Partner ID#
_____	_____
Partner Signature	Date

Reproductive Medicine and Infertility Associates

EMAIL CONSENT FORM

_____	_____	_____
Patient's Name (printed)	DOB	Clinic ID number

_____
Patient's e-mail address

EMERGENCY PROBLEMS
E-mail should never be used for **emergency situations.** In the event of an emergency, call 911

URGENT PROBLEMS
E-mail should never be used for **urgent situations**. In these cases, the patient should call our main number 651-222-6050 during business hours (M-F 7:30-4:30). After hours you can contact our on call answering service or go to an urgent care.

1. **RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR CLINIC**
   Reproductive Medicine & Infertility Associates referred throughout this consent as "Clinic."

   The Clinic offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patient should consider before using e-mail to communicate with the Clinic. These include, but not limited to, the following risks:
   - E-mail can be circulated, forwarded, and stored in numerous paper and electronic files
   - E-mail sender can type in the wrong email address
   - Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
   - Employers have a right to archive and inspect e-mails transmitted through their system.
   - E-mails can be used to introduce viruses into computer systems
   - E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
   - E-mails can be used as evidence in court.

2. **CONDITIONS FOR THE USE OF E-MAIL**
   Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, the Clinic cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure and confidential information that is not caused by the Clinics intentional misconduct. Thus, patient must consents to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:
   a) All e-mails concerning diagnosis or treatment will become part of the patients medical records.
   b) Patient shall not use e-mails for medical emergencies, urgent problems or other sensitive matters.
   c) If the patient has not received a response back from the Clinic within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
   d) The patient acknowledges the risk in using e-mail for communication regarding sensitive medical information, such as information regarding, but not limited to laboratory testing, mental health, or health history.
   e) The patient is responsible for protecting his/her password or other means of access to e-mail. The Clinic is not liable for breaches of confidentiality caused by the patient or any third party.
   f) Clinic shall not engage in e-mail communication that is unlawful.
   g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS**

To communicate by e-mail, the patient shall:

a) Limit or avoid use of his/her employer's computer
b) Inform Clinic of changes in his/her e-mail
c) Put the patient's name in the body of the e-mail.
d) Include the category of the communication in the e-mail's subject line
e) Review the e-mail to make sure it is clear and that all relevant information is provided before sending the e-mail.
f) Take precautions to preserve the confidentiality of the e-mail, such as using screen savers and safeguarding his/her computer password.

4. **ALTERNATE FORMS OF COMMUNICATION**

I understand that I may also communicate with the Clinic via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. Appointment should be made to discuss any new issues as well as sensitive medical information. I also understand that the Clinic also utilizes Notify MD as I go through active treatment and that is also a way to communicate results and changes in my treatment plan.

5. **TYPES OF E-MAIL TRANMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE**

The types of information that can be communicated by e-mail with the Clinic include prescription refills, patient referrals and appointment scheduling reminders and requests, billing and insurance questions, consultation summaries, signed consent forms, **IVF treatment plan (calendar) and instructions,** and patient education. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should call the Clinic to schedule an appointment. If you elect not to provide us with your email, but contact us through e-mail, we will correspond to any email sent to us.

In most occasions, you will receive an encrypted email via ZixMail. You must provide a username and password to log into ZixMail to retrieve your message(s). The Clinic will be notified of any message not picked up. The Clinic will make one attempt to resend via ZixMail or will mail document(s) to you. **If you do not receive our email(s), please check your spam or junk mail folder. If you find it there, please identify it as "non-junk" or "non-spam" email. You may also want to add noreply@rmia.com to your contact or 'Safe Sender' list so that these emails do not go to your junk mail folder.**

6. **SECURITY MEASURES USED BY CLINIC**

As stated above, communication via e-mail does come with privacy risks as stated above. While the Clinic can not guarantee total confidentiality, the Clinic will use reasonable safeguards to protect your health information as required by law.

7. **HOLD HARMLESS**

I agree to hold harmless the Providers, Reproductive Medicine & Infertility Associates, its employees, and website designers against all losses, expenses, damages, costs, including attorney's fees, relating to information loss due to technical failure. The Clinic does not warrant that the functions contained in any material provided will be uninterrupted or error-free, that defects will be corrected, or that the Clinic website or server that makes such site available is free of viruses or other harmful components.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Clinic representative and we acknowledge that I have read and fully understand the consent form. We understand the risks associated with the communication of e-mail between the Clinic and us, and consent to the conditions herein.

Date: ____/____/____ _____ 7642-_____
Patient Signature Clinic ID

Date: ____/____/____ _____ 7642-_____
Partner Signature Clinic ID

TO BE SIGNED BY PATIENT

REPRODUCTIVE MEDICINE & INFERTILITY ASSOCIATES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Reproductive Medicine &Infertility Associates (RMIA). Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this Authorization below.

This Authorization is voluntary and only applies to protected health information related to medical care received by RMIA. Treatment or payment for services are not conditioned on signing the authorization.

I understand that the information that is used or disclosed in accordance with this Authorization may be subject to re-disclosure by the Recipient(s) listed below and, in that case, will no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time prior to its expiration date by providing written notification to Michael Stein, Privacy Officer, Reproductive Medicine &Infertility Associates, 2101 Woodwinds Drive, Suite 100, Woodbury, MN 55125, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that RMIA took before it received the revocation.

This Authorization shall remain in effect until either: (a) its expiration date of 1 year, on _____ or (b) RMIA receives a written revocation of the authorization.

ACCEPTANCE

☐ I, _____, hereby authorize the use or disclosure of my protected health information to the following person(s):

NAME OF PERSON #1 _____

NAME OF PERSON #2 _____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

DECLINATION

☐ I, _____, hereby decline authorization to use or disclose my protected health information to anyone. *(Patient must also sign "HIPAA Request for Limitations & Restrictions of PHI" ED-597)*

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

I authorize continuation of this release (authorization will be valid for another year):

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

TO BE SIGNED BY PARTNER, IF APPLICABLE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Reproductive Medicine &Infertility Associates (RMIA). Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this Authorization below.

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PATIENT SIGNATURE_____ DATE_____ ID 7642-_____

PATIENT SIGNATURE_____ DATE_____ ID 7642-_____