

COOPER INSTITUTE FOR REPRODUCTIVE HORMONAL DISORDERS
DONOR OOCYTE PROGRAM
8001F GREENTREE COMMONS
MARLTON, NJ 08053
856-810-7853

APPLICATION # _____

Today's date: ____/____/____

RECIPIENT APPLICATION FORM

NAME: _____ PARTNER NAME: _____
last first mi last first mi

ADDRESS: _____
city state zip code

PHONE # _____ - _____ - _____ WORK # _____ - _____ - _____

CELL # _____ - _____ - _____ E-MAIL: _____

Would you like to receive your donor listing by email? _____ If yes, we will use the email address above

Date of Birth: ____/____/____ Age: _____ SS#: ____/____/____

Current Ob/Gyn: _____
full name address

Duration of current marriage or relationship: _____ years Duration of infertility: _____ years

Date of last menstrual period: ____/____/____ Days between menstrual periods _____ to _____

Why has it been advised for you to use donor eggs?:
(circle) Premature Ovarian Failure Non-Ovulation
 Increased Age (over age 40) Other _____

Please circle other infertility factors: Tubal Cervical Factor Endometriosis Malefactor Unexplained

Have you ever had a hysterosalpingogram (HSG) performed? yes no If "yes", please give dates and results

Date	Performed by	Results

Have you had previous fertility treatment? yes no Excluding IVF, please list and describe

PREGNANCY DATA

Please list any pregnancies and detailed information below

Date	Outcome	Infertility Treatment (Indicate type)	# of Months Needed to Conceive	Type of Delivery	Sex	With Current Partner?
		Y N			M F	
		Y N			M F	
		Y N			M F	
		Y N			M F	

IVF HISTORY

Indicate the number of previous IVF and/or GIFT/ZIFT cycles if applicable _____ Record detailed information regarding prior cycles

Date	Clinic	Medications	# Eggs	# Fertilized	ICSI?	# Transfer	Pregnancy Outcome

Do you take medications of any kind? Please include any over-the-counter medications taken on a regular basis, vitamins, etc. Include dosage if known.

CHARACTERISTICS

Height: _____ Weight: _____ Build: Small Medium Large
(Circle)

Hair Color: Black Lt Brown Brown Dk Brown Auburn Red Lt Blonde Blonde Dk Blonde
(circle)
Wavy Straight Curly

Eye Color: Blue Gray Green Hazel Brown Black
(circle)

Skin Tone: Fair Light Medium Dark Olive Lt Olive Dk Olive
(circle)

Race: _____

Ethnicity: _____

Blood Type: A Pos A Neg B Pos B Neg AB Pos AB Neg O Pos O Neg Unsure
(circle)

Please indicate date of testing and results of the following, also, list any treatment

Test	Date Performed	Results (circle one)	Treatments
Rubella Immunity		immune non-immune	Vaccinated?
Chlamydia Culture		positive negative	
Mycoplasma Culture		positive negative	
Pap Smear		normal abnormal	
Mammogram		normal abnormal	

MALE CHARACTERISTICS

Date of Birth: ____ / ____ / ____

SS#: ____ / ____ / ____

Height: _____

Weight: _____

Build: _____ Small Medium Large
(circle)

Hair Color: Black Lt Brown Brown

Dk Brown Auburn Red Lt Blonde

(circle) Blonde Dk Blonde

Wavy Straight Curly

Eye Color: Blue Gray Green

Hazel Brown Black

Skin Tone: Fair Light Medium

Dark Olive Lt Olive Dk Olive

(circle)

Race: _____

Ethnicity: _____

Blood Type: A Pos A Neg B Pos B Neg AB Pos Ab Neg O Pos O Neg Unsure
(circle)

Please use this space provided to indicate the characteristics that you deem important for your donor. Please return the necessary fee with your application. Applications to be mailed to: Cooper Institute for Reproductive Hormonal Disorders, Donor Egg Program, 8001F Greentree Commons, Marlton, NJ 08053, ATTN: Donor Egg Program.

I/we have answered the above questions honestly and to the best of my/our knowledge and ability. I understand that this information will be used and relied on by the IVF program. I understand that knowingly or intentionally providing false information will be a cause for disqualification as an egg recipient.

DATE: ____ / ____ / ____

SIGNATURE: _____
(patient)

DATE: ____ / ____ / ____

SIGNATURE: _____
(partner)