

## **PENINSULAR CENTRE FOR REPRODUCTIVE MEDICINE**

### **Egg Sharing Protocol/Information/Consent**

Because it is very common for more eggs than are needed to be obtained during the course of IVF treatment some clinics, including our own, have started schemes to enable couples who need egg donation (known as 'recipient' couples) to undergo IVF treatment using eggs from a donor couple who themselves need IVF treatment but who may be unable to afford the cost. Under our scheme screening and treatment are arranged as usual, but the eggs that are harvested are shared between the two or more couples. The recipient couple or couples pay for cost for their own treatment, but the donor couple receive treatment at very much reduced cost.

The possibility exists, as with all forms of IVF treatment, that it may not succeed and for the same sorts of reasons as occur in normal IVF cycles e.g. failure of the donor to respond adequately to the drugs, failure to obtain any or enough eggs at the egg recovery operation, failure of eggs to fertilise, failure of embryos to implant.

The donor couple in the egg-sharing scheme receive their own treatment at very much reduced cost, but each couple is responsible for their own preliminary consultation and investigation costs. In some cases general practitioners may have a record of or be willing to undertake preliminary investigations.

#### **The following should also be noted:**

1. Even under ideal circumstances couples undergoing IVF run a small risk that only a few (or even no) eggs may be obtained. The chances of this are less with egg sharing (because of the selection criteria) than with many IVF treatments. If the number of eggs obtained is small (3 or less per couple) it may be advisable to fertilise them by ICSI (at no extra charge) to give the best possible fertilisation rate. Except where there is a need to undertake ICSI because of a known sperm problem this method would not be used to fertilise the eggs when there are four or more eggs per couple unless specifically requested. In that case the clinic would charge its standard supplement for ICSI.
2. Egg sharing is a relatively new concept. Complex ethical and other dilemmas not covered above or in the Clinic's 'Egg Sharing Protocol' may arise in the course of treatment that may have been difficult to anticipate. The Clinic reserves the right to resolve these at its discretion within the regulations and guidelines set out by the HFEA;
3. The standard screening, consent and other procedures for egg donation, for which there are separate information leaflets, apply. Whilst the clinic would make every effort to ensure that donors would only be considered suitable if there are not likely to be any inheritable or other problems that could be transmitted to a recipient or child and also that there would be no known factors on the donor's part which may reduce the chances of success from her eggs, there may be implications in using eggs from donors who themselves have fertility problems. Where possible, donor and recipient couples will be selected from different geographic areas such that they would be likely to receive maternity care in different hospitals. In order to minimise the chance that donor and recipient couples may inadvertently be related or know each other both couples would be invited to submit to the clinic a 'Contact List' of names of close friends and relatives to whom this might apply.
4. Couples should consider the implications for any children born from treatment regarding the possibility that they may grow up having half-brothers or half-sisters about the same age and of whom they are unaware.

5. Independent counselling (arranged within the clinic) is generally a necessary requirement for both donor and recipient couples;

### **Eligibility to be an egg-sharing donor:**

1. The donor should be before her 36<sup>th</sup> birthday on the day of egg collection
2. Screening tests (as outlined on the clinic's information sheet for egg donation) should be normal
3. The questionnaires to assess 'Welfare of Child' issues and the likelihood of transmitting serious inheritable diseases should be completed and found to be free from problems
4. The woman should have two normal ovaries (polycystic ovary syndrome, ovarian cystectomy, or the previous removal of part of an ovary may cause ineligibility), with ovarian volume measurements > 3cms<sup>3</sup> on ultrasound scanning
5. There should be a baseline FSH hormone level (blood taken during first five days of cycle) of <7 mIU/ml
6. There should not be a history of previous poor response to ovulation induction treatment
7. Body mass index should be >19 and <30
8. Priority would be given to non-smokers

### **Selection/matching of couples**

Donors/recipients would be matched in so far as possible for

- \* racial type (always)
- \* hair colour
- \* eye colour
- \* general build
- \* CMV (Cytomegalovirus infection) status

### **Contingencies:**

The HFEA have produced guidelines for Clinics undertaking egg-sharing which, in particular, require that during such treatment the interests of the **DONOR** must be considered paramount with respect to the clinical procedures undertaken and choices of different courses of action which may arise. Bearing this in mind:

- Donors and recipients may be required to pay for their own preliminary consultation and investigation costs as detailed on the Clinic's schedule. The cost to the recipient couple is as per our published schedule Treatment is free to the donor couple except for the HFEA fee or costs of supplementary treatments as required (e.g. the use of donor sperm or ICSI).
- Eggs up to a maximum of twelve are shared between a primary recipient and donor 50:50 with odd numbers going to the donor. In the event that more than 12 eggs are obtained the additional eggs may be fertilised by the sperm from the male partner(s) of one or more 'secondary' recipient couples with a view to the initial freezing and storage of all embryos thereby created. Provided these embryos survive the process they may subsequently be replaced into the appropriate recipient.
- If the donor couple withdraw from treatment the primary recipient couple would receive a refund of the treatment cost paid to the clinic excluding the cost of drugs obtained for

their own use. There would be no charge to the donor couple except for any unused and un-returned drugs previously dispensed to them;

- If the recipient couple withdraw during the course of a treatment cycle for non-medical reasons, any fees paid or costs already incurred would not be refunded

**The following contingency plans apply in the event of small numbers of follicles, eggs or embryos:**

- a final decision would not be made whether to proceed to egg collection and IVF until or unless eight or more preovulatory follicles were seen on ultrasound scanning of the donor. In the event that there were fewer than eight preovulatory follicles as judged by the clinic’s staff treatment would be abandoned\*. In this case the recipient couple would receive a refund of their treatment cycle fee
- the minimum total number of eggs obtained at the egg collection operation for sharing to proceed is six
- in the event that fewer than six eggs were obtained, the donor couple would be offered the option to continue with IVF treatment using all of their own eggs obtained at the egg collection and with no further financial or other commitment on their part.
- in this event the donor couple could, if they wished, continue to egg collection and IVF using any eggs collected entirely for themselves and for a reduced fee of £600 or else no charge in the event that no eggs at all were obtained. The HFEA require that in order to enable this option the £600 fee must be paid prior to the start of treatment by the donor couple so that they do not feel under financial pressure at the time but would be refunded in the event that the option was not taken up.

**CONSENT:** I/we have read the above information relating to egg sharing and agree to abide by the procedures and requirements as outlined above: We understand that apart from preliminary consultations and tests the costs will be

£.....:

plus (*complete/delete as appropriate*).. £ for... Donor  
Sperm/ICSI/PESA/Embryo freezing

Signed: .....

Date:

Signed (for the Clinic): .....

Date:

## PENINSULAR CENTRE FOR REPRODUCTIVE MEDICINE

### AGREEMENT TO DONATION OF EGGS FOR IN-VITRO FERTILISATION

I,

.....  
agree to the donation of my eggs to a woman/women who needs donated eggs in order to become pregnant. I agree to undergo the procedures for in-vitro fertilisation that are necessary for this. I have read the information sheet provided and understand that:

1. I will be tested for HIV and other infections. I understand the implications of these tests.
2. I will have no future rights or claims to the donated eggs or embryos resulting from their fertilisation and that there can be no commitment by the Peninsular Centre for Reproductive Medicine to retain any donated eggs or resulting embryos for my own use should my circumstances change.
3. Identifying information will be held in a central register by the Human Fertilisation and Embryology Authority.
4. A child born as a result of egg donation once he or she reaches the age of 18 years (or 16 if contemplating marriage) may on request receive identifying information concerning the donor and her last recorded address.
5. A child born disabled as a result of my failure to disclose defects about which I have, or ought reasonably to have had, knowledge may be able to sue me for damages.

I will allow my eggs to be used for a maximum of ..... (up to 10) families.

6. I have had a full discussion with

.....  
on ..... and understand that the methods to be used may include:

- i) The administration of hormones and other drugs described in the attached schedule;
- ii) Egg retrieval by means of

.....  
iii) Fertilisation with the man of the recipient couple's semen/a suitable donor's semen (\* delete as appropriate) of any eggs obtained from me

iv) The possible use of intracytoplasmic injection of sperm to fertilise the eggs  
v) Maintenance of embryos resulting from such fertilisation until such time as, in the view of the medical and scientific staff, they are ready for replacement in the recipient woman;

7. I consent to these procedures and to the administration of such drugs and anaesthetics to myself as may be necessary. I also consent to any further operative measures that may be found to be necessary in the course of the treatment.

8. I consent that any embryos which are not replaced within five days of egg collection to the recipient woman or women could, at the discretion of the medical staff, be preserved by freezing or other methods and stored for a period of not more than ..... (maximum of

five) years from the date of fertilisation with a view to replacement in a recipient woman on another occasion.

(9.) I agree that after the period specified in (8) has expired the Hospital or Centre may dispose of the stored embryos at its discretion

(10). I understand that I may change at any time by notifying the Centre the terms of my consent as above with respect to the duration of storage and disposal of the frozen embryos.

11. I have read the Information Leaflets for Patients of the above Centre relating to IVF and Egg Donation (Leaflet ID: \_\_\_\_\_ and have understood what is involved with these procedures.

12. I have been given time to consider the contents of this document and have been given the opportunity to make such further enquiries as I wish before signing.

13. I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

14. If it comes to the attention of the Centre that a child born from my eggs is found to have an inheritable disease which may have implications for me or my family I am/am not (delete as appropriate) willing to be informed.

15. I agree, subject to rights and freedoms afforded by law, to take all reasonable steps to keep my treatment confidential with respect to protecting the anonymity of donors, recipients and children born from treatment.

16. We understand the clinic's policy regarding refunds for self-funded patients, which is that: *- deposits or advance payments for treatments may not be refundable if couples withdraw from their allotted treatment for non-medical reasons. In some circumstances the clinic may make a refund at it's discretion if it is possible to fill the treatment slot with another couple.*

Woman's signature ..... Date:  
.....

Signed: ..... Date: .....  
(for the Centre)

## PENINSULAR CENTRE FOR REPRODUCTIVE MEDICINE

### Preconsultation questionnaire for potential sperm or egg donors

Please complete and bring this questionnaire with you to the first clinic appointment.

Full name of potential donor.....

Date of birth:

Address:

Telephone number: .....

Full name of partner.....

How long have you been married/living together?.....

Numbers of children and ages for:

Potential donor

Partner

Any illnesses of note of the potential donor's children?

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

### PHYSICAL AND OTHER CHARACTERISTICS OF DONOR:

Height	Weight	Hair Colour	Eye Colour	Skin colour	Ethnic origin	Occupation

### FAMILY HISTORY:

**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

**YES/NO**

If yes, state .....

