

<b>Donor Code: V082K</b>		
<b>Legislation type: New</b>		
<p>Following a major review of Victoria's assisted reproductive treatment laws, State Parliament last year passed the Victorian Assisted Reproductive Treatment Amendment Bill (2021). This resulted in several legal changes which have now come into effect and are designed to provide better and fairer access to assisted reproductive treatment in Victoria.</p> <ul style="list-style-type: none"> <li>This donor has been counselled and consented to these changes and therefore falls under the new legislation. If you have received counselling after the 15<sup>th</sup> of August 2022 these changes should have been discussed with you, if prior we will arrange for you to receive top up counselling at no charge to use this donor under the new legislation.</li> </ul>		
<b>Consent Expiry: 28/11/2033</b>		
<p><b>Maximum permitted storage period:</b> Donor V082K will reach the maximum storage period on 13/01/2034 Following the donor's consent and storage expiry, if you still have sperm in storage that you wish to use in treatment it may be possible to apply for a storage extension. Please speak with your donor coordinator.</p>		
<b>Vial Type:</b> IVF/ICSI	<b>On donation available:</b> Yes. Please speak with your donor coordinator to check that a family allocation is available.	
<b>Donor available for reservation in Vic</b>		
<b>Blood type:</b> O Rh(D) Positive		
<b>Cytomegalovirus (CMV) Status:</b> Positive		
<p>As this sperm donor is CMV Positive the person/s planning to carry may require additional documentation in the form of a Risk Acknowledgement form to proceed with this donor. Please refer to your CMV Fact Sheet or your IVF Specialist if you have questions around your own CMV status</p>		
<b>Additional testing requirements:</b>		
<p>This donor has undertaken genetic screening for Expanded carrier screening (ECS) and has been found to be a carrier of the below listed condition/gene:</p> <ul style="list-style-type: none"> <li>GBE1- related conditions</li> <li>Metachromatic Leukodystrophy <i>ARSA</i></li> </ul> <p>To proceed with this donor, further screening is required for the person/s eggs being used in conjunction with this sperm donor:</p> <ul style="list-style-type: none"> <li>Extended Carrier Screening (ECS)</li> </ul>		
<b>Monash IVF Fertility Specialist and Genetics Comments</b>		
Please this donor underwent a reduced ECS panel and therefore a lower number of genes were screened.		
<b>Current Screening Guidelines as of 2023</b>		
Test name	Initial screening	Quarantine screening
HIV 1 & 2 Antibodies	✓	✓
Hepatitis B Surface Antigen	✓	✓
Hepatitis B Core Antibody	✓	✓
Hepatitis C Core Antibody	✓	✓
Hepatitis C RNA PCR	<i>not required</i>	✓
Syphilis	✓	✓
CMV Antibodies (IgG/IgM)	✓	✓
HTLV I&II	✓	✓
Chlamydia urine PCR	✓	✓
Gonorrhoea urine PCR	✓	✓
Mycoplasma Genitalium urine PCR	✓	✓
Full Blood Examination + Film review	✓	<i>not required</i>
Blood Group	✓	<i>not required</i>
Banded Karyotype	✓	<i>not required</i>
Haemoglobin Electrophoresis	✓	<i>not required</i>
Cystic Fibrosis Screen	✓	<i>not required</i>
Spinal Muscular Atrophy Screen	✓	<i>not required</i>

Donor Details			
Donor Code or RMU:		Date Donor Profile Completed:	
Donor Type:	<input type="checkbox"/> Clinic Recruited Donor		<input type="checkbox"/> Recipient Recruited/Known Donor
	<input type="checkbox"/> Sperm Donor	<input type="checkbox"/> Egg Donor	<input type="checkbox"/> Embryo Donor: <input type="checkbox"/> Sperm Source / <input type="checkbox"/> Egg Source <i>Note: Both donors must provide a declaration</i>

In accordance with Legislation, regulations and Monash IVF Policy, certain non-identifying donor information must be provided to Monash IVF before a donation can proceed. In line with your consent to donate your sperm, eggs or embryos, this information will be held by Monash IVF and will be provided to:

- potential or actual recipient(s) of your donation
- any children born as a result of your donation
- Government Donor Conception Registers and/or clinic held registers in the event a pregnancy or live birth results from your donation.

We ask that you please answer each question contained within this form. You may also choose to include other additional information for your profile. Please ensure you do not include any identifying information about yourself or any members of your family in this document. This document is a fillable PDF.

Donor Information		
Place of Birth	Town/State:	Country:
Ethnicity:		Religion (if any):
First Language:		Other Language/s (if any):
Occupation:		

Current Relationship Status				
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> De Facto	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed

Blood Group							
<input type="checkbox"/> O+	<input type="checkbox"/> O-	<input type="checkbox"/> A+	<input type="checkbox"/> A-	<input type="checkbox"/> B+	<input type="checkbox"/> B-	<input type="checkbox"/> AB+	<input type="checkbox"/> AB-

Genetic Carrier Screening Status <i>(if known)</i>	Cytomegalovirus (CMV) Status <i>(if known)</i>

Educational Level	Certificates Attained/Highest Year Level Completed
<input type="checkbox"/> Secondary	
<input type="checkbox"/> Tafe/Vocational Training	
<input type="checkbox"/> Tertiary	

Do you have your own children?  No  Yes (please complete table below)

Gender of Each Child	Year of Birth	Hair Colour	Eye Colour

Physical Characteristics					
Height (cm)			Weight (kg)		
Build	<input type="checkbox"/> Slim	<input type="checkbox"/> Athletic	<input type="checkbox"/> Medium	<input type="checkbox"/> Solid	<input type="checkbox"/> Large
Complexion	<input type="checkbox"/> Fair	<input type="checkbox"/> Freckled	<input type="checkbox"/> Medium	<input type="checkbox"/> Olive	<input type="checkbox"/> Dark Brown
Eye Colour	<input type="checkbox"/> Blue	<input type="checkbox"/> Green	<input type="checkbox"/> Hazel	<input type="checkbox"/> Grey	<input type="checkbox"/> Brown
Natural Hair Colour	<input type="checkbox"/> Blonde	<input type="checkbox"/> Red	<input type="checkbox"/> Light Brown	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
Hair Texture	<input type="checkbox"/> Fine	<input type="checkbox"/> Medium	<input type="checkbox"/> Coarse	<input type="checkbox"/> Thick	
	<input type="checkbox"/> Wavy	<input type="checkbox"/> Straight	<input type="checkbox"/> Curly		

Biological Parents Physical Characteristics					
	Height (cm)	Build	Complexion	Natural Hair Colour	Eye Colour
<b>Mother</b>					
<b>Father</b>					

Biological Parents and Grandparents Country of Birth and Ethnicity		
	Country	Ethnicity
<b>Mother</b>		
<b>Father</b>		
<b>Maternal Grandmother</b>		
<b>Maternal Grandfather</b>		
<b>Paternal Grandmother</b>		
<b>Paternal Grandfather</b>		

Do you have any personal or professional interests?

Please describe your personality/temperament.

**Please describe your attitude/philosophy in life.**

**What do you think makes you unique?**

**How would you describe your childhood? And what value were you taught?**

**Who were the most influential people in your upbringing? And what were they like?**

**Please explain why you wish to become a donor.**

**Do you have a message for a child conceived from your donation?**

Please ensure you do not include any identifying information about yourself or any members of your family in the following pages of this document.

<b>To be completed by Monash IVF</b>
Donor Code: V082K

Donor Details			
Date Donor Profile Completed: 27/09/2023			
Donor Type:	<input checked="" type="checkbox"/> Sperm Donor	<input type="checkbox"/> Egg Donor	<input type="checkbox"/> Embryo Donor: <input type="checkbox"/> Sperm Source / <input type="checkbox"/> Egg Source <i>Note: Both donors must provide a declaration</i>

Please describe your general health:
Excellent health with very active lifestyle.

Health Questions			
Do you smoke?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you drink alcohol?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you or have you engaged in any recreational drug use?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Do you exercise/engage in physical activity?	<input type="checkbox"/> No / <input type="checkbox"/> Occasionally / <input checked="" type="checkbox"/> Often	10	hrs per week
Do you have issues with your eyesight?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	Do you wear glasses?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
Do you have issues with your hearing?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	Do you wear hearing aids?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
Have you had a fever and/or illness within the last three months?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have you travelled out of Australia in the last six months?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have you or any member of your extended family had consultations at a genetic clinic?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
<i>Please provide further details if you answer yes.</i>			
Have you or any member of your extended family been diagnosed with a genetic condition?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
<i>Please provide further details if you answer yes.</i>			
Have any members of your extended family died suddenly at an early age?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
<i>Please provide further details if you answer yes.</i>			

Please ensure you do not include any identifying information about yourself or any members of your family in the following pages of this document.

Some of the listed conditions below are known to be genetic or have a genetic contribution, meaning that they could be inherited by a donor conceived child. If **you or any member of your family** has been diagnosed as being affected by one of these conditions or as being a carrier of one of these conditions, please tick yes and add the age of onset. If a relative has been affected by the condition, describe the relationship of the person to yourself (i.e. grandparent, parent, sibling, aunt, uncle or cousin). If you would like to provide further information about any condition(s) you indicate as yes, please add this information in the box at the end of this document.

Auto Immune Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Lupus	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Multiple Sclerosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scleroderma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Rheumatoid Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoarthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoporosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sjogren's Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Kidney Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Polycystic Kidney Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Born with one kidney	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Urinary tract disorders	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Neurological Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Attention-Deficit Hyperactivity Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Autism Spectrum Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Asperger's Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Chromosome Condition (e.g. Down syndrome)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Dyslexia Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Chronic Migraines	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Alzheimer's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Huntington's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cerebral Palsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Creutzfeldt-Jakob Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Friedreich Ataxia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Parkinson's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Spina Bifida	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Tourette Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Intellectual Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Neurofibromatosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Spinal Muscular Atrophy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other Neurological Conditions <i>If yes, please provide details</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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<b>Cancer</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Breast	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lung	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Skin	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bowel	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lymphoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Melanoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other cancer <i>If yes, please provide details</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Blood Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Haemochromatosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Anaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Haemophilia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sickle Cell Anaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thalassemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Skeletal Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Muscular Dystrophy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Marfan Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scoliosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Skeletal Dysplasia (e.g. Achondroplasia)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Cardiovascular Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Arrhythmia condition (e.g. Long QT Syndrome)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cardiomyopathy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Heart Attack	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
High Cholesterol	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Structural Heart Defect from Birth	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sudden Cardiac Death	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Mental Health</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Clinical Depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Schizophrenia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bipolar Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Obsessive-Compulsive Disorder (OCD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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Metabolic/Endocrine						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Tay-Sachs Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 1 Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	61	Paternal Grand Mother
Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Genetic Metabolic Condition (e.g. Phenylketonuria -PKU)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypoglycaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Congenital Malformations						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Cleft Lip/Palate	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Talipes/Club Foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypospadias	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Undescended Testicles	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Polydactyly	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other congenital abnormalities <i>If yes, please provide further details</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Respiratory Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Cystic Fibrosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Food)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Drug)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Pet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Hay fever)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Skin Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Psoriasis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Eczema	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Albinism	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Vitiligo (pigmentation disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Sight/Sound Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Colour Blindness	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cataracts	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Glaucoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Retinoblastoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Macular Degeneration	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Deafness	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		



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<b>Gastrointestinal Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Crohn's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcers	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Diverticulitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcerative Colitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>If you have ticked yes to any of the above, please can you provide further information.</b>
<p><i>i.e. have you or your family ever had genetic testing performed? if so, were there any additional investigations?</i>            Yes, for my donations with Melbourne IVF, genetics tests were conducted by INVITAE. Findings are-</p> <p>Carrier of GBE1-related conditions.            GENE - GBE1.            VARIANTS - c.1472_1475delinsGGC (p.Ala491Glyfs*4)            INHERITANCE - Autosomal Recessive</p> <p>Carrier of Methachromatic Leukodystrophy (ARSA-related)            GENE - ARSA            VARIANTS - c.925G&gt;T (p.Glu309*)            INHERITANCE - Autosomal Recessive</p>

<b>Monash IVF Fertility Specialist and Genetics Comments (to be completed by Monash IVF if applicable)</b>