

<b>Donor Code: LD2U</b>		
<b>Maximum permitted storage period:</b> Donor LD2U will reach the maximum storage period on 25/01/2037 Following this date 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.		
<b>Vial Type: ICSI</b>	<b>On donation available: Yes</b>	
<b>Donor available for reservation in NSW (5 Family Allocations)</b>		
<b>Blood type: 0+</b>		
<b>Cytomegalovirus (CMV) Status: Positive</b>		
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		
<b>Additional testing requirements:</b>		
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: Congenital adrenal hyperplasia due to <ul style="list-style-type: none"> <li>GNE related conditions</li> </ul> To proceed with this donor, further screening is required for the person/s eggs being used in conjunction with this sperm donor: <ul style="list-style-type: none"> <li>Expanded carrier screening with comparable panel</li> </ul>		
<b>Monash IVF Fertility Specialist and Genetics Comments</b>		
<b>Current Screening Guidelines</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 Non-Identifying Information

Donor Details			
Donor Code: LD2U		Date Completed: 14.9.2022	
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

In accordance with current regulations, legislation and Monash IVF Policy, the following non-identifying information for all donors must be provided to Monash IVF. This information will be made available to:

- recipient(s) of your donation
- children born as a result of your donation
- recorded on the State and/or Clinic Registers if a pregnancy and/or birth are achieved by the recipient(s).

Please advise your Donor Co-Ordinator if any information you have included on this form changes, including any medical or genetic information you are made aware of after the donation has been completed.

We ask that you please answer each question contained within this form. 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: <i>proddatur</i> <i>Proddatur/AP</i> Country: INDIA
Ethnicity:	INDIAN Religion (if any): HINDU
First Language:	TELUGU Other Language/s (if any):
Occupation:	SENIOR MANAGER

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

Blood Group							
<input checked="" 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	Cytomegalovirus (CMV) Status
Positive - Carrier for GNE - related conditions	IgG detected, IgM negative

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

Do you have your own children?  N/A

Gender of Each Child	Year of Birth	Hair Colour	Eye Colour
MALE	2009	BLACK	BLACK

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Physical Characteristics					
Height (cm)	171		Weight (cm)	79 kg	
Build	<input type="checkbox"/> Slim	<input type="checkbox"/> Athletic	<input checked="" type="checkbox"/> Medium	<input type="checkbox"/> Solid	<input type="checkbox"/> Large
Complexion	<input type="checkbox"/> Fair	<input type="checkbox"/> Freckled	<input checked="" 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 checked="" 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 checked="" type="checkbox"/> Black
Hair Texture	<input type="checkbox"/> Fine	<input type="checkbox"/> Medium	<input checked="" 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
Mother	155	Medium	Medium	Black	Black
Father	171	Medium	Medium	Black	Black

Biological Parents and Grandparents Country of Birth and Ethnicity		
	Country	Ethnicity
Mother	India	Indian
Father	India	Indian
Maternal Grandmother	India	Indian
Maternal Grandfather	<del>India</del>	<del>to Indian</del>
Paternal Grandmother	<del>to India</del>	<del>to Indian</del>
Paternal Grandfather	<del>to India</del>	<del>to Indian</del>

**Please describe your general health:**

No health issues. Very fit

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 exercise/engage in physical activity?	<input type="checkbox"/> No / <input type="checkbox"/> Occasionally / <input checked="" type="checkbox"/> Often	3	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

Donor Details	
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Do you have any personal or professional interests?

Flute artist, painting, fitness, travel

Please describe your personality/temperament.

Soft natured, Introvert

Please describe your attitude/philosophy in life.

Positive

What do you think makes you unique?

My skills

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

close knit family, happy childhood

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

My parents

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

Help families in need of a child.

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

Work hard & by hard.

The following is a list of conditions that 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 Disorders						
	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"/>		
Scleroderma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sjogren's Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Kidney Disease						
	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 Disease						
	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"/>		
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 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"/>		

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Neurological Disease						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
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"/>		
Multiple Sclerosis	<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"/>		
Guillain Barre Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Fatal Familial Insomnia (FFI)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Gertsman-Straussler-Scheinker Syndrome (GSS)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Neurofibromatosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Cancer						
	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"/>		
Melanoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Tumour	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Blood Disorders						
	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"/>		
Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thalassemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Muscular/Bones/Joints						
	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"/>		
Spinal Muscular Atrophy	<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"/>		
Scoliosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Achondroplasia (Dwarfism)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoporosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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Cardiovascular Disease						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Long QT Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Heart Disease	<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"/>		

Mental Health						
	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"/>		
Intellectual Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Obsessive-Compulsive Disorder (OCD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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 checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cleft Palate	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
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"/>		

Respiratory Disease						
	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"/>		
Bronchiectasis	<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"/>		

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Skin						
	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						
	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"/>		

Gastrointestinal Disease						
	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"/>		

Please feel free to add further information relating to any conditions you ticked yes to above.