

Donor Code: LD4L		
Maximum permitted storage period: Donor LD4L will reach the maximum storage period on 30/03/2038 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.		
Vial Type: ICSI	On donation available: Yes	
Donor available for reservation in NSW and WA (5 Family Allocations)		
Blood type: O+		
Cytomegalovirus (CMV) Status: Positive		
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		
Additional testing requirements:		
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"> Leber congenital amaurosis type 13 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"> Expanded carrier screening with comparable panel 		
Monash IVF Fertility Specialist and Genetics Comments		
Current Screening Guidelines		
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: LD4L		Date Donor Profile Completed: 13/06/2023	
Donor Type:	<input type="checkbox"/> Clinic Recruited Donor		<input type="checkbox"/> Recipient Recruited/Known Donor
	<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>

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: Shenyang/Liaoning	Country: China
Ethnicity: Asian		Religion (if any):
First Language: Mandarin		Other Language/s (if any): English
Occupation: Accountant		

Current Relationship Status				
<input checked="" type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> De Facto	<input 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 (if known)	Cytomegalovirus (CMV) Status (if known)
GCS Positive - see medical history for details	CMV IgG Positive

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

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) 179			Weight (kg) 74		
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 checked="" type="checkbox"/> Medium	<input type="checkbox"/> Coarse	<input type="checkbox"/> Thick	
	<input type="checkbox"/> Wavy	<input checked="" type="checkbox"/> Straight	<input type="checkbox"/> Curly		

Biological Parents Physical Characteristics					
	Height (cm)	Build	Complexion	Natural Hair Colour	Eye Colour
Mother	160	Medium	Medium	Black	Brown
Father	175	Medium	Medium	Black	Brown

Biological Parents and Grandparents Country of Birth and Ethnicity		
	Country	Ethnicity
Mother	China	Asian
Father	China	Asian
Maternal Grandmother	China	Asian
Maternal Grandfather	China	Asian
Paternal Grandmother	China	Asian
Paternal Grandfather	China	Asian

Do you have any personal or professional interests?
I have a bunch of things I really enjoy doing. For starters, I love going on trips with my friends and exploring new places. Playing the piano is another passion of mine, where I can express myself through music. Swimming is something I find really relaxing and refreshing. When it comes to entertainment, I enjoy watching movies, playing Online and board games. These activities bring me a lot of joy and let me connect with others in different ways.

Please describe your personality/temperament.
I would describe myself as an ISFJ-A personality type. I have a calm and introverted temperament. When I face challenges, I tend to approach them with a rational mindset, carefully analysing problems and paying attention to details. Overall, I'm a laid-back person who rarely gets angry and prefers to maintain a positive perspective.

Please describe your attitude/philosophy in life.

In life, I hold the belief that there is an abundance of beauty waiting to be explored and uncovered. I approach it with a positive mindset, embracing people and experiences with open arms. I strongly believe in maintaining a good mood as it plays a vital role in navigating life's ups and downs.

What do you think makes you unique?

I believe everyone is unique, including myself. What makes me distinct is the way I perceive and embrace my own value and beauty. I strive to recognise my individuality and appreciate the qualities and experiences that shape me. Moreover, I find meaning in contributing to others and society. Whether it's through acts of kindness, sharing knowledge, or making a positive impact, I believe in using my unique strengths to make a difference.

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

During my childhood, I experienced a happy and fulfilling time that was balanced with hard work in my studies. I was fortunate to have a loving and supportive environment. From an early age, I was taught the value of understanding the diversity of the world, appreciating different cultures and beliefs. I was also instilled with the belief that opportunities are for those who are prepared. Overall, my childhood provided a solid foundation for my character and outlook on life.

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

My mom was the most influential person in my upbringing. She is open-minded, diligent, capable, understanding, and reasonable. Communication is highly valued by her, and she always listens and offers advice when I have something on my mind. Her impact on me has been profound, shaping my character and values.

Please explain why you wish to become a donor.

I wish to become a donor because I believe in creating value and making a positive impact on society. By assisting individuals and couples in their journey to start a family, I can play a role in bringing joy and fulfillment to their lives. It's an opportunity to make a meaningful difference and create a positive effect in society.

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

While I understand that it is beyond my control, I sincerely hope that you have a wonderfully happy life filled with joy and fulfillment. I wish for you to embrace each day with a radiant smile and a heart full of happiness.



Donor Medical and Genetic Questionnaire Donor Non-Identifying Information

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

To be completed by Monash IVF
Donor Code: LD4L

Donor Details			
Date Donor Profile Completed: 22/05/2023			
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:
I am in good overall health.

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 checked="" type="checkbox"/> Occasionally / <input type="checkbox"/> Often	5 - 10 hrs per week	
Do you have issues with your eyesight?	<input type="checkbox"/> No / <input checked="" type="checkbox"/> Yes	Do you wear glasses?	<input type="checkbox"/> No / <input checked="" 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 checked="" 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? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have you or any member of your extended family been diagnosed with a genetic condition? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have any members of your extended family died suddenly at an early age? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		

Donor Medical and Genetic Questionnaire

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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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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"/>		
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"/>		

Blood Conditions						
	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"/>		

Skeletal Conditions						
	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"/>		

Cardiovascular Conditions						
	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"/>		

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"/>		
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 checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
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 type="checkbox"/>	<input checked="" type="checkbox"/>	1	<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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Gastrointestinal Conditions						
	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"/>		

If you have ticked yes to any of the above, please can you provide further information.

i.e. have you or your family ever had genetic testing performed? if so, were there any additional investigations?

To my knowledge, no genetic testing has been conducted within my family.

During primary school, I developed nearsightedness and began wearing glasses regularly. However, my condition has not worsened over time.

According to my mom, I developed eczema when I was one month old.

Monash IVF Fertility Specialist and Genetics Comments (to be completed by Monash IVF if applicable)

Positive carrier:
Leber congenital amaurosis type 13
RDH12



