

Donor Code: MQ191022		
<p>Maximum permitted storage period: Donor MQ191022 will reach the maximum storage period on 25/11/2032. 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.</p>		
<p>Donor available for reservation in QLD 10 family allocations</p>		
<p>Blood type: O+</p>		
<p>Cytomegalovirus (CMV) Status: Positive</p>		
<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>		
<p>Additional testing requirements:</p>		
<p>This donor has undertaken genetic screening for Expanded carrier screening (ECS) and has returned a negative result for all screened tests. Further genetic screening is therefore not mandatory to proceed with using this donor.</p>		
<p>Monash IVF Fertility Specialist and Genetics Comments</p>		
<p>Donor MQ191022 is outside of recommended age and there is a small increased risk of autosomal dominant mutations, autism, schizophrenia (while relative risk is 2-3 times absolute risk is less than 2%).</p>		
<p>Current Screening Guidelines as of 2023</p>		
Test name	Initial screening	Quarantine screening
HIV 1 & 2 Antibodies	✓	✓
Hepatitis B Surface Antigen	✓	✓
Hepatitis B Core Antibody	✓	✓
Hepatitis C Core Antibody	✓	✓
HCV 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>
Extended Genetic Carrier Screening	✓	<i>Not Required</i>

Donor Details			
Donor Code: MQ191022		Date Completed: 20/10/2022	
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: Danang Country: Vietnam
Ethnicity: Vietnamese	Religion (if any):
First Language: Vietnamese	Other Language/s (if any): English, Cantonese
Occupation: health professional	

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	Cytomegalovirus (CMV) Status
Negative	Past exposure positive

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

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Physical Characteristics					
Height (cm) 165			Weight (cm) 60kg		
Build	<input checked="" 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 checked="" 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 checked="" type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
Hair Texture	<input type="checkbox"/> Fine	<input type="checkbox"/> Medium	<input type="checkbox"/> Coarse	<input checked="" 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	155	slim	brown	black	brown
Father	165	slim	brown	black	brown

Biological Parents and Grandparents Country of Birth and Ethnicity		
	Country	Ethnicity
Mother	Vietnam	Vietnamese
Father	Vietnam	Vietnamese
Maternal Grandmother	Vietnam	Vietnamese
Maternal Grandfather	Vietnam	Vietnamese
Paternal Grandmother	Vietnam	Vietnamese
Paternal Grandfather	Vietnam	Vietnamese

Please describe your general health:
good health

Health Questions			
Do you smoke?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you drink alcohol?	<input type="checkbox"/> No / <input checked="" type="checkbox"/> Yes	per day 0.2	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 checked="" 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 checked="" type="checkbox"/> No / <input type="checkbox"/> Yes

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Do you have any personal or professional interests?
I like to play mind games, chess and Texas Holdem. I like reading and learning languages.

Please describe your personality/temperament.
I am calm and determined.

Please describe your attitude/philosophy in life.
I am happy and content with life. I am generous.

What do you think makes you unique?
After arriving in Australia, I could get into a good university course and I became a health professional very fast.

How would you describe your childhood? And what value were you taught?
I had a good and joyful childhood. I was taught to love and to respect.

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

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Please explain why you wish to become a donor.
I want to pass on good genes, compassion, healthy and slow-ageing, intelligent.

Do you have a message for a child conceived from your donation?
be generous, be optimistic and care about life.

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 type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	60	throat cancer, 1st cousin

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 type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>		Mother
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.

Donor MQ191022 is just outside of recommended age and there is a small increased risk of autosomal dominant mutations, autism, schizophrenia (while relative risk is 2-3 times absolute risk is less than 2%)

