

<b>Donor Code: V085T</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>Cytomegalovirus (CMV) Status: Positive</b>		
<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: N/A</b>		
<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>		
<b>Current Screening Guidelines as of 2020</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:		Date Completed:	
Donor Type:	<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

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:	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	Cytomegalovirus (CMV) Status

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?  N/A

Gender of Each Child	Year of Birth	Hair Colour	Eye Colour

Donor Details	
Donor Code:	Date Completed:

Physical Characteristics					
Height (cm)			Weight (cm)		
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>		

Please describe your general health:

Health Questions			
Do you smoke?	<input type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you drink alcohol?	<input 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 type="checkbox"/> Often		per week
Do you have issues with your eyesight?	<input 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 type="checkbox"/> No / <input type="checkbox"/> Yes	Do you wear hearing aids?	<input type="checkbox"/> No / <input type="checkbox"/> Yes

**Donor Details**

Donor Code:

Date Completed:

**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?**

## Donor Details

Donor Code:

Date Completed:

Please explain why you wish to become a donor.

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

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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sjogren's Syndrome	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Born with one kidney	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Urinary tract disorders	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Dyslexia Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Chronic Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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Date Completed:

### Neurological Disease

	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Creutzfeldt-Jakob Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Friedreich Ataxia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Tourette Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Guillain Barre Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Fatal Familial Insomnia (FFI)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Gertsmann-Straussler-Scheinker Syndrome (GSS)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Neurofibromatosis	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lung	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Skin	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bowel	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Tumour	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Haemophilia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sickle Cell Anaemia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Leukaemia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thalassemia	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Marfan Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Spinal Muscular Atrophy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Achondroplasia (Dwarfism)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoporosis	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
High Cholesterol	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Obsessive-Compulsive Disorder (OCD)	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Phenylketonuria (PKU)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypoglycaemia	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Club Foot	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypospadias	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Undescended Testicles	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Polydactyly	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bronchiectasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Food)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Drug)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Pet)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Hay fever)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

## Donor Details

Donor Code:	Date Completed:
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### Skin

	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Albinism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Vitiligo (pigmentation disorder)	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Retinoblastoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Deafness	<input 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 type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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