OREGON HEALTH & SCIENCE UNIVERSITY

Department of Obstetrics & Gynecology
Fertility Consultants
Andrology/Embryology Laboratory

www.fertilityoregon.com
fertlab@ohsu.edu

Center for Health & Healing
3303 SW Bond Avenue, Mail Code CH10F
Portland, OR 97239-4501
Tel 503 418-3700
Fax 503 418-3708

Recipient Insemination Information and Physician's Authorization

Recipient:

Name _____ , _____ ___ / ___ / _____
Last First Date of Birth

Address _____ _____ _____ _____
Street City State Zip

Home phone (__ __ __) __ __ __ - __ __ __ __ Day phone (__ __ __) __ __ __ - __ __ __ __

email _____@_____ Occupation _____

Circle one: Married Single Living with Partner Living with Registered Partner

Partner:

Name _____ , _____
Last First

Day phone: (__ __ __) __ __ __ - __ __ __ __

email _____@_____ Occupation _____

Selecting an OHSU Sperm Donor: *(This information may be provided later, check on donor availability)*

I / We have reviewed the OHSU Andrology Sperm Donor Profiles and authorize the use of donors listed below for therapeutic insemination.

1st Choice Donor # __ __ __ __ 2nd Choice Donor # __ __ __ __ 3rd Choice Donor # __ __ __ __

Selecting an Non-OHSU Sperm Donor:

I / We authorize the use of Donor # _____ from _____ sperm bank for therapeutic insemination.

If my blood type is Rh negative, I recognize that I must inform my obstetrician that if I have been inseminated with an Rh positive donor so that I may receive appropriate care during pregnancy.

_____ ___ / ___ / _____
Recipient signature Date

Physician Authorization: I authorize OHSU University Fertility Consultants Andrology Laboratory to release donor semen specimens to (Recipient name) _____ name for the purpose of achieving a pregnancy in an assisted reproductive procedure. I have informed the recipient of the risks and limitations of the procedure. The assisted reproductive procedure will be performed under my direction and supervision, or the procedure may be delegated to a physician or clinic which I authorize. The recipient has agreed that all specimens obtained from University Fertility Consultants Andrology Laboratory are for her personal use only.

_____ _____ ___ / ___ / _____
Physician signature print name Date

Clinic/ Hospital/ Center _____

Address _____ _____ _____ _____
Street City State Zip