Notification of Medical or Genetic Concerns By Embryo Donation Recipients

Assisted Reproductive Technologies

Introduction:

As a courtesy to the wonderful patients who donated their embryos, we ask that you notify Embryo Donation International (EDI) of any significant medical or inheritable diseases that are found in your donated embryo offspring. The information you provide here may be of use to the **Donating Parents**, their relatives and other families who may also have received donated embryos from this same couple.

We have also asked the **Embryo Donor Parents** to notify us if any of their relatives and their children are found to have a new significant medical or genetic disease that could influence the future medical care of your donated embryo offspring.

Identifying Information:

Since you may have moved, please update your identifying information below:

Name at time of Embryo Donation:		Year of Embryo Donation Procedure:
Current Name:		Birth Date:
Current Address:		
City:	State	Zip Code
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Physician Name:

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Please provide us with the physician's name that made the diagnosis. Please be sure to sign a release of information form so that we may speak to the physician. We will not breach confidentiality issues and will not tell them of your reproductive history. We will simply need to know of the medical issues.

Physician Name:	Type of Physician:	Phone Number:

Genetic Concerns:

Please keep this form in a safe location and notify us should it become necessary:

Child's Name	Age of Diagnosis	Actual Diagnosis	Consequences of Diagnosis (Use separate paper if needed)

Please feel free to us additional paper, if needed.

Contact Us If Uncertain:

If you are uncertain if a disease is significant or genetic (i.e., inheritable), please ask your physician or call us here at EDI. We thank you for your assistance in keeping the **Donating Parents** and the staff here at EDI informed.

_____	_____	___/___/___
Recipient's Signature	Recipient's Name (print)	Date
_____	_____	___/___/___
Partner's Signature	Partner's Name (print)	Date
_____	_____	___/___/___
EDI Coordinator's Signature	EDI Coordinator's Name (print)	Date
_____	_____	___/___/___
Physician's Signature	Physician's Name (print)	Date

Initials:	Date: