# **FORM 13**

[Refer Rule 13 (f) (viii)]

## Consent Form for the Donor of Oocytes

**I,** {full\_name}, residing at {address}, District: {district}, State: {state}, PIN Code: {pin\_code}, Mobile: {contact\_number}, Aadhaar Number {aadhaar\_number}, willingly consent to donate my oocyte to couples who are unable to have a child by other means. At this stage and to the best of my knowledge I am free of any infectious diseases or genetic disorders.

I have had a full discussion with **{doctor\_name}**

on {date\_of\_discussion}, at {ivf\_name}, {ivf\_address}.

(I understand that there will be no direct or indirect contact between me and the recipient, and my personal identity will not be disclosed to the recipient or to the child born through the use of my gamete: If applicable)

I understand that I shall have no rights whatsoever on the resulting offspring and vice versa.

I understand that the method of treatment may include:

1. Stimulating my ovaries for multifollicular development.

2. The recovery of one or more of my eggs under ultrasound-guidance or by laparoscopy under sedation or general anesthesia.

3. The fertilization of my oocytes with recipient’s husband’s or donor sperm and transferring the resulting embryo into the recipient.

I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side-effects like nausea, headaches, and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified in time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

**Name, address and signature of woman**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{full\_name}  
Address: {address}, District: {district}, State: {state}, PIN Code: {pin\_code}

## Endorsement by the ART Clinic

We have personally explained to {full\_name}, the details and implications of her signing this consent/approval form, and made sure to the extent humanly possible that she understands these details and implications.

Name, address and signature of the Witness from the clinic

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{ivf\_name},{ivf\_address}

Name and signature of the Doctor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
{doctor\_name}

Name and address of the ART clinic  
{ivf\_name}, {ivf\_address}

Name and address of the ART bank that recruited and screened the donor  
Cryoconserve, 3rd Floor, 59/1, 2nd Block, Rajajinagar, Bengaluru-560010

Dated: {date}