


### Instructions on completing the Sperm Donation Consent Form

All sections must be initialed as indicated.

On some pages, you will be required to fill in selections then initial in several places. Please ensure that your selections are clearly marked in the indicated boxes along with your initials.

Example:

Please initial	
<b>C.M.</b>	<b>2017/09/14</b>
<i>Donor Initials</i>	<i>Date YYYY/MM/DD</i>



### Consent Signature Page (page 2):

You should clearly print your name, fill requested information, and sign where indicated in the presence of a witness.

The witness may be anyone who knows you well (neighbor, friend, relative, etc.). The role of the witness to the signatures is simply to confirm the identity of the patient and partner signing the consent form. The witness should clearly print his/her name and then sign the form.

Please make a copy of the signed consent form to keep for your records.



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**Please note that our nursing staff cannot issue a treatment calendar if this consent is incomplete or missing from your chart.**

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Should you have any questions or concerns regarding this consent form, please call 514-843-1650 for a consent appointment with a medical staff member.



**Sperm Donor**

RAMQ
First Name
Last Name
Date of Birth (YYYY/MM/DD)
Hospital Card Number

Please check the box if you are the directed sperm donor.

**Sperm Donation**

I consent to donate my sperm for the reproductive purposes of the Intended Parent(s) named below.


\_\_\_\_\_ \_\_\_\_\_  
*Intended Parent #1* *Date of Birth (YYYY/MM/DD)*

\_\_\_\_\_ \_\_\_\_\_  
*Intended Parent #2 (if applicable)* *Date of Birth (YYYY/MM/DD)*

I am aware that as a donor I have no rights or responsibilities to any future offspring created with my sperm.

Please initial

Donor Initials	Date YYYY / MM / DD
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I understand and have been informed of:

**Counselling and Legal Aspects**

- The requirement of psychological consultation;
- The MUHC Reproductive Centre (the Clinic) cannot provide legal advice regarding sperm donation; however, consulting with an attorney is recommended.
- I have made this decision to donate sperm of my free will without any coercion or undue influence;
- I agree to complete the donor information form before the start of treatment;
- The Clinic will not inform me of any pregnancy resulting from the use of my donated sperm.

### Treatment

- Blood tests for transmissible diseases are required before my sperm can be donated. If test results are abnormal, or not available, or not up to date, my semen sample will not be used;
- It is my responsibility to inform the Clinic of any newly diagnosed illness or infection or any exposure to such a situation;
- The staff of the Clinic may review my medical chart for selecting potential participants in a research study approved by the MUHC review board and the central ethics board of the Ministry;
- It is my responsibility to inform the Clinic of a change of address. I may be contacted in the future for long-term follow-up;

### Withdrawal of Consent

- I may withdraw my consent to donate sperm by notifying the Clinic in writing; however, I cannot withdraw consent once my samples have been thawed and allocated to the Intended Parent(s).
- The withdrawal of the consent will be acknowledged in writing by a member of the professional staff of the Clinic.

### Signature of Consent

I understand that the laws of Canada and of the Province of Quebec shall govern the relationship between myself and the Clinic and any health professional involved in my care.

<b>PATIENT CONSENT</b>			
I have been given time to consider the content of this document and the opportunity to make further inquiries before signing this form. I consent to the described treatment.			
_____	_____	_____	_____
<i>Donor's Name (Print)</i>	<i>Signature</i>	<i>Place (City)</i>	<i>Date (YYYY/MM/DD)</i>
_____	_____	_____	_____
<i>Witness Name (Print)</i>	<i>Signature</i>	<i>Place (City)</i>	<i>Date (YYYY/MM/DD)</i>

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