



Department of Obstetrics and Gynecology  
 University Fertility Consultants  
 Andrology/Embryology Lab  
[www.fertilityoregon.com](http://www.fertilityoregon.com)

Center for Health and Healing  
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**INSEMINATION RECIPIENT INTAKE FORM** P. 1 OF 2

**RECIPIENT**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: ( ) \_\_\_\_\_ Day Phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Circle one: Married Single Living with Partner Religion: (optional) \_\_\_\_\_

**PARTNER**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  
 Day phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ Religion: (optional) \_\_\_\_\_

**Recipient's Physical Characteristics: (optional)**

Height: \_\_\_\_\_ Hair color/texture: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Complexion: \_\_\_\_\_ Eye color: \_\_\_\_\_ Blood type/Rh factor: \_\_\_\_\_  
 Race: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

**Husband/Partner's Physical Characteristics: (optional)**

Height: \_\_\_\_\_ Hair color/texture: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Complexion: \_\_\_\_\_ Eye color: \_\_\_\_\_ Blood type/Rh factor: \_\_\_\_\_  
 Race: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

**Method of Donor Selection (please check only one: A, B, or C)**

A. OHSU Sperm Bank - Patient Selects Donor  
 I/we have reviewed the OHSU Andrology Lab Donor Profiles on sperm donors and I/we authorize the use of the donors listed below for therapeutic insemination. Please call the lab to check donor availability.

1st choice donor # \_\_\_\_\_ 4th choice donor # \_\_\_\_\_  
 2nd choice donor # \_\_\_\_\_ 5th choice donor # \_\_\_\_\_  
 3rd choice donor # \_\_\_\_\_ 6th choice donor # \_\_\_\_\_

B. OHSU Sperm Bank - Andrology Lab Selects Donor  
 I/we authorize the OHSU Andrology Lab to select appropriate donors for therapeutic insemination based upon the Desired Donor's Physical Characteristics listed below and donor availability. I/we understand that the desired race will always be matched; that for other Physical Characteristics, the Andrology Lab will select the best match available.

Same as husband/partners: \_\_\_\_\_ (If "no", circle choices below.)  
 Height: (give range) less than 5'6" 5'6" 5'7" 5'8" 5'9" 5'10" 5'11" 6'0" 6'1" 6'2" 6'3" 6'4" greater than 6'4"  
 Weight: less than 140 lbs 140-160 lbs 160-180 lbs 180-200 lbs greater than 200 lbs  
 Body Build: Larger Medium Slender Complexion: Fair Medium Dark Olive  
 Hair Color: Blond Brown Black Red Hair Texture: Straight Wavy Curly Thick Thin Fine  
 Eye Color: Brown Blue Blue-Green Hazel Hazel-Green Green  
 Race: \_\_\_\_\_ Ethnic background: \_\_\_\_\_

C. Non-OHSU Sperm Bank (for local recipients only, or those needing storage)  
 I/we authorize the use of donor # \_\_\_\_\_ from \_\_\_\_\_ sperm bank facility.  
 If my blood type is Rh negative, I recognize that I must inform my obstetrician that I may have been inseminated with an Rh positive donor so that I may receive appropriate care during pregnancy.

\_\_\_\_\_  
 Signed, Recipient Date

**Physician Authorization**

I authorize University Andrology Lab at OHSU and its sperm bank to release donor semen specimens to (recipient's name) \_\_\_\_\_ for the purpose of achieving a pregnancy in an assisted reproductive technology procedure. I have informed her of the risks and limitations of the procedure. The assisted reproductive technology procedure will be performed under my direction and supervision, or the procedure may be delegated to a physician/clinic which I authorize. She has agreed that all specimens obtained from University Andrology Lab are for her personal use only.

Physician: \_\_\_\_\_ Date : \_\_\_ / \_\_\_ / \_\_\_  
Signature Please print name

Clinic/Hospital/Center: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

Comments:(to be completed by local interviewer) \_\_\_\_\_

\_\_\_\_\_  
Interviewer signature: \_\_\_\_\_

Discussed: Stats:\_\_\_ Fees:\_\_\_ HIV/HCV Quarantining:\_\_\_ Scheduling:\_\_\_ Donor Screening:\_\_\_ Keeping in touch:\_\_\_  
Registration:\_\_\_ Donor Selection:\_\_\_