SPERM DONATION INTAKE

File No.:

Check one:

Client's name: **Donor __ Recipient __**

Address:

County: Birth date:

Home phone: Fax:

Work phone: E-mail:

Check one:

Other party's name: **Donor __ Recipient __**

Address: Birth date:

Egg supplied by: Recipient ___ 3d party donor ___

PSYCHOLOGICAL AND MEDICAL TESTING CONDUCTED: Donor ___

Recipient ___

SPERM DONATION

Anticipated donation date(s):

FERTILITY DOCTOR'S NAME:

Address:

Phone:
Fax:

COMPENSATION TO DONOR: $_____

Payable upon: Donation? _____ Other: _____

EXPENSES (check those to be paid by Recipient):

Direct Expenses will be paid by: Recipient___ Donor___
(All medical costs of sperm donation, including physician or third party provider bills incurred in connection with medical screening of donor, fertility testing, medications, and medical procedures associated with the donation)

Direct Psychological Expenses paid to Donor? Paid by Recipient ___ None ___
(The cost of psychological screening and/or counseling of donor)

Miscellaneous Expenses? Paid by Recipient ___ Cap $_____
(Please specify in detail such items as travel, lodging, etc.)

Attorneys' Fees for Recipient's attorney paid by: Recipient ____

Cap $_____ **Donor ____**

Attorneys' Fees for Donor's attorney paid by: Recipient ____

Cap $_____ **Donor ____**

Does Donor give permission for his identity to be revealed to any child born as a result of the sperm donation?