



Notification of New Genetic Concerns By Embryo Donors, EDI Assisted Reproductive Technologies

Embryo Donation International (EDI) is a subsidiary of Specialists in Reproductive Medicine and Surgery, P.A. (SRMS) and will be referenced throughout this document.

Introduction:

We ask that you notify **SRMS-EDI** of any new inheritable diseases that are discovered in your family. The information you provide here may be of significant use to the **Embryo Donor Recipients** and their embryo donation offspring.

We have also asked the **Embryo Donor Recipients**, the recipients of your wonderful gift, to notify us if any of the children that resulted from Embryo Donation process are found to have a genetic disease that could influence the future medical care of you and your family.

Identifying Information:

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

Name(s) at time of Embryo Donation:		Year you donated embryos:
Current Name(s):		Birth Date(s):
Current Address:		
City:	State	Zip Code
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Physician Name:

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 kind gift. We will simply need to understand the medical issues.

Physician Name:	Type of Physician:	Phone Number:
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New Genetic Concerns:

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

Individual’s Name (How related?)	Age at 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 genetic (i.e., inheritable), please ask your physician or call us here at SRMS-EDI. We thank you for your assistance in keeping the **Embryo Donor Recipients** and the staff here at SRMS-EDI informed. Thank you again for your wonderful gift.

_____ Woman’s Signature	_____ Woman’s Name (print)	____/____/____ Date
_____ Partner’s Signature	_____ Partner’s Name (print)	____/____/____ Date
_____ SRMS-EDI Nurse Coordinator Signature	_____ SRMS-EDI Nurse’s Name (print)	____/____/____ Date
_____ SRMS-EDI Physician’s Signature	_____ SRMS-EDI Physician’s Name (print)	____/____/____ Date

Initials:	Date:
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