TCATF 392 03 Page 1 of 1

**Donor Initial Enquiry Questionnaire**

I am interested in becoming an egg/sperm donor and would like an appointment to discuss this further.

|  |  |
| --- | --- |
| Name (Block Capitals):  |       |
| Age:  |       | Egg Donor [ ]  Sperm Donor [ ]  |
| Date of Birth:  |       |
| Address:  |       |
|  |       |
| Telephone (Daytime):  |       | (Mobile): |       |
| Email Address:  |       |
| Occupation:  |       |
| GP Name:  |       |
| GP Practice:  |       |

|  |  |  |
| --- | --- | --- |
| Were you adopted?  |  [ ]  Yes | [ ]  No |
| Do you smoke?  |  [ ]  Yes | [ ]  No |
| Height       ft / cm Weight       Kg |
| Can you give details of biological family medical history to grandparents on both sides?  | [ ]  Yes |  [ ]  No |
| Are you aware of any genetic illnesses in your biological family?  | [ ]  Yes |  [ ]  No |
| Have you donated eggs or sperm elsewhere? | [ ]  Yes |  [ ]  No |
| If Yes: Place of donation       | Number of families created       |

|  |  |  |
| --- | --- | --- |
| Have you travelled outside the UK in the last year or are you planning on travelling prior to or during your donation?  | [ ]  Yes  |  [ ]  No |
| If YES, date of travel:        |  Location:       |
| Please note any specific requests that you wish us to consider here: |
|       |
|  How did you hear about the Sperm Donation Programme? [ ]  Facebook [ ]  Instragram [ ]  Twitter [ ]  Radio [ ]  Television [ ]  Other (give details:)       |
| What is your motivation for becoming a donor?      |
| Please indicate the preferred method of contact: Email [ ]  Telephone [ ] By providing my details and my preferred method of contact I consent to receiving correspondence from the Fertility Centre about my application. I am aware that the information collected from me on this form, including personally identifiable information, which if relevant will include my gender history, will be stored securely and will be shared with relevant members of staff, including staff from other Fertility Centres and from SNBTS, involved in the management of the donation process, while ensuring confidentiality at all times.  |
| Name of Donor (Print): |       Signature of Donor: |  Date:       |
| Completed by staff member over telephone? |  [ ]  Yes [ ]  No | Name of staff member: |       Date:       |

**This document is the property of the Scottish Government National Fertility Group and permission must be sought before any adaptation or use of this form**