

Reproductive Biology Associates
Pre-Cycle Screening Requirements for Anonymous Egg Recipient

Name: _____

Date: _____

Female Partner

Screening Bloodwork:

_____ HIV	_____ TSH
_____ Hepatitis B Surface Antigen	_____ ABO Rh
_____ Hepatitis C Antibody	_____ Rubella Titre
_____ RPR	_____ Varicella Titre

Genital Cultures:

_____ Gonorrhea
_____ Chlamydia

General Health Screening:

_____ Pap Smear
_____ Mammogram(>40 yrs)
_____ ~Flexible Sigmoidoscopy(>50 yrs)
_____ *Medical Clearance Letter(>45 yrs)

~note: only updated every 5 years

*note: any recipient 45 or older must have a clearance letter from a primary care physician stating the patient is healthy to achieve a pregnancy.

Other Testing:

_____ Sonohysterogram or Hysterosalpingogram
_____ Sounding (trial transfer)

Male Partner

Screening Bloodwork:

_____ HIV
_____ Hepatitis B Surface Antigen
_____ Hepatitis C Antibody
_____ RPR
_____ ABO Rh

Other Testing:

_____ Semen Analysis

Both Partners

_____ Psychological Consult (both partners MUST attend)

_____ Profile

_____ Consents

(done once)