



Northern
California
Fertility
Medical
Center, Inc.
An Ivy Center

Northern California Fertility Medical Center

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It's our standard recommendation that oocytes be used at the center where they were frozen. The center freezing the oocytes is most familiar with their freezing methods and therefore it is in the patient's best interest to utilize the oocytes where they were created. **Generally, we do not accept outside oocytes.** We realize that there may be extenuating circumstances, and we may consider accepting oocytes frozen at other clinics after a thorough case review.

OOCYTE INTAKE FORM / SART INFORMATION

to be completed by the facility currently storing the oocytes

Patient Name: _____ **Patient DOB:** _____

Partner Name: _____ **Partner DOB:** _____

Shipping Clinic Name: _____

of Frozen Specimens to ship: _____ **# of cryo devices to ship:** _____

Freeze Date(s): _____

Type of Cryo Device(s): _____

Cryopreservation Method: Vitrification Slow Freeze Other _____

Thaw/Warming Media / manufacturer / ref#: _____

SART / CDC DATA

Egg Source: Autologous Donor

Oocyte Donor Agency/Donor ID: _____ **Donor DOB or Age:** _____

Oocyte Donor Type: Anonymous Known Genetic Donor Known non-genetic Donor

Retrieval Type: Fresh Oocyte Frozen Oocyte

Retrieval Date: _____ **Number of Oocytes Retrieved:** _____

Stimulation: Unstimulated Minimal Stimulation Agonist Flare

Agonist Suppression Antagonist Suppression

Ovulation Trigger: HCG only GnRH agonist only Both HCG/GnRH No Trigger

Medication: FSH - dosage: _____ Medication with LH/HCG Activity

Clomid - dosage: _____ Letrozole - dosage: _____

Tamoxifen - dosage: _____ Other - dosage: _____

Intended Use:

Embryo creation with sperm source: Partner Donor

Sperm Donor Type: Anonymous Known Genetic Donor Known non-genetic Donor

Embryo transfer to: Self Gestational Carrier/Surrogate

For Shipping Oocytes to NCFMC, please provide the following:

Thawing/Warming Protocols

Cryopreservation Report with freezing dates and description of frozen oocytes

If gametes are for autologous use and/or sexually intimate partners, screening test results (HIV, HTLV, Hep B, Hep C, Syphilis)

If donor tissue was used (eggs or sperm), FDA donor eligibility determination (SOR) and/or all FDA required screening test results

California Tissue Bank License Number and FDA Registration Number