



**SPERM DONOR GENETIC TEST RESULTS**

**Donor # 7319**

**DONOR CARRIER STATUS**

I have received the genetic test results for this donor, and he is known to carry a mutation for the following recessive condition(s): **Increased Carrier Risk: Spinal muscular atrophy (SMN1) Risk is 1/33**

**FAIRFAX CRYOBANK HAS ADVISED ME:**

| I should discuss the donor's test results with the doctor who will perform my fertility procedure, or a genetic counselor, to help me interpret the results and determine whether, and what kind of, genetic testing is appropriate for me (or my egg donor).  |  |                |  |  |                         |
|--|--|----------------|--|--|-------------------------|
| There are limitations to the technology and sensitivity of carrier screening and to the analysis of its results, which are described in the donor's laboratory report. These limitations include, but are not limited to, incomplete assessment of some genes and the inability to further delineate the size and content of a deleted region. As such, the test may not identify a donor's carrier status for all conditions and is not meant to screen all regions of the donor's genome.    |  |                |  |  |                         |
| If the biological parents' genetic test results indicate that they are not carriers for the same recessive condition, then the risk that the resulting child will have that condition is significantly reduced. The risk cannot be eliminated entirely, as no genetic test is 100% accurate.   |  |                |  |  |                         |
| <b>If both biological parents are carriers for the same recessive condition, then any resulting child is at increased risk for having that condition. Fairfax Cryobank strongly recommends that I (or my egg donor) have carrier testing for the genetic condition(s) listed above, which can be ordered by my doctor.</b>   | <table border="1"> <tr> <th colspan="2" data-bbox="1187 1003 1429 1058">ACKNOWLEDGMENT</th> </tr> <tr> <td data-bbox="1187 1058 1279 1136"></td> <td data-bbox="1279 1058 1429 1136">Intended Parent Initial</td> </tr> </table> | ACKNOWLEDGMENT |  |  | Intended Parent Initial |
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|  | Intended Parent Initial  |                |  |  |                         |
| Genetic counseling may be available through my doctor's office. There is a list of independent genetic counselors available at <a href="http://www.nsgc.org">www.nsgc.org</a> .  |  |                |  |  |                         |
| I have the option to seek a full refund of what I paid for vials from this donor for up to 45 days after purchase as long as vials have not been shipped or picked up. I also have the option to exchange the vials for another donor at any time as long as the vials have not been shipped or picked up; if I select more expensive vials, then I will be charged for the difference. Once donor sperm has left Fairfax Cryobank, it cannot be exchanged or returned for a refund or credit. |  |                |  |  |                         |

**I HAVE READ AND UNDERSTOOD THIS DOCUMENT:**

| SIGNATURE                              |               |
|--|---------------|
| Intended Parent/Client Signature       | Date          |
|  |               |
| Printed Name of Intended Parent/Client |               |
|  |               |
| Complete Home address                  | Date of Birth |
|  |               |

Fairfax Cryobank, Inc. must receive this completed form prior to shipping sperm from this donor.