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CONSENT TO EVALUATION
DONOR AND GESTATIONAL CARRIER CANDIDATES

Candidate name: _____ D.O.B._____
Partner name: _____ D.O.B._____
Address:_____
Phone number(s):_____
Email address:_____
Name of referring agency or clinic:_____
Name(s) of the financially responsible party:_____

If the financially responsible party is not an agency or clinic, please provide the following information:
Name:_____
Address:_____
Phone number(s):_____
Email address:_____

What to Expect: The psychological evaluation for donor and gestational carrier candidates involves a clinical interview and completion of a standardized, self-report objective personality inventory. This inventory assesses general personality traits, attitudes and behaviors, and mental health symptoms, as well as the test taker's approach to answering the questions on the inventory. Completion time for both the interview and psychological testing is approximately two hours.

Due to health and safety concerns posed by the COVID-19 Pandemic, all psychological services are currently being provided remotely through a HIPAA-compliant video platform. You will need a camera-enabled device and to have your camera turned on in order to participate in the evaluation.

If you have a spouse or significant other, they will need to participate in the interview portion of the evaluation (first hour), IF you are either:

1) A gestational carrier candidate or
2) A directed (known personally to the recipients)* egg or sperm donor

*This requirement does not apply to non-directed (i.e. "agency") egg/sperm donor candidates

Purpose of the Evaluation: The primary purpose of the evaluation is to assess whether a candidate meets psychological criteria for serving as a donor or gestational carrier. The evaluation is not meant to be an in-depth, comprehensive psychological evaluation that would have bearing on other aspects of the candidate's life. Many complex factors determine whether a candidate is determined to meet the psychological criteria for serving as a donor or carrier. If the evaluator determines that the candidate does not meet psychological criteria for the role of donor or carrier, it does not mean that the candidate has a psychological problem that warrants concern. A second purpose of the evaluation is to help donor or carrier candidate explore and assess some of the different emotional and psychological implications related to serving as a donor or carrier. During the evaluation, the evaluator will discuss and explore with the candidate some of the potential psychological risks and benefits related to serving as donor or gestational carrier, considering that candidate's personal history and unique life circumstances. However, ultimately, the candidate must weigh the potential risks and benefits and decide for him or herself whether it is the right decision for him or her.

Potential Risks: There are risks involved in participating in a psychological evaluation. Certain questions or topics may trigger uncomfortable feelings or self-awareness or may bring to light differences in perspectives between partners. In addition, the evaluator may conclude that the candidate does not meet the psychological guidelines, meaning that the candidate may not have the opportunity to serve as a donor or carrier. This may lead to feelings of rejection, shame, disappointment, sadness, or anger.

Transmission of Evaluation Results: After the evaluation is completed, a report will be written that summarizes information obtained in the interview and testing, and makes a statement about whether the candidate has been determined to meet psychological criteria for serving as a donor or gestational carrier. This report will be released to the referring agency or clinic. Information that, in the opinion of the evaluator, is relevant to the recipients or intended parents may also be released directly to the recipients or intended parents. In the case of a non-directed/non-identity disclosed (i.e. "agency") donor, this will not involve any personally identifying information. The candidate will not receive a copy of the report and only limited feedback about the recommendations will be available to the candidate.

Confidentiality: There are some disclosures by a candidate that would require or permit the Dr. Dinsmore to release otherwise confidential information to other parties. These include:
1) Threat of clear and imminent harm to self or others,
2) Clear indication of abuse or neglect of a child, elder, or cognitively impaired individual,
3) If records are subpoenaed or court ordered to be released

Federal law (HIPAA) requires that the privacy of a candidate's health information be protected and that the candidate be informed in writing of how protected information may be used or disclosed and how a candidate may access this information. A written copy of HIPAA policies is available upon request.

Rights: You have the right to request information about Dr. Dinsmore's training and experience. You also have the right to request a referral for another appropriately qualified mental health provider who may be able to conduct the evaluation. You have the right to refuse to participate in the evaluation, although your referring agency or clinic may be unwilling to allow you to participate in serving as a donor or carrier without a psychological evaluation. You have the right to discontinue your participation in the evaluation at any time. Finally, you have the right to revoke your consent for the information obtained in the evaluation to be released to parties you initially authorized release to, except for information that has already been released. However, your referring agency or clinic may be unwilling to allow you to participate in serving as a donor or carrier without the release of this information.

Consent to Terms of Evaluation: Your signature below indicates that you:
1) Understand the conditions outlined above and agree to undergo a psychological evaluation under these conditions
2) Have received a copy of the HIPAA policies/procedures if you have requested one
3) Understand/ agree that no doctor-patient relationship exists between Dr. Dinsmore and yourself
4) You will not hold Dr. Dinsmore legally responsible for decisions or outcomes resulting from this evaluation or the records created by it.

_____	_____
Printed Name of Candidate	Date of Birth
_____	_____
Signature of Candidate	Date
_____	_____
Printed Name of Partner	Date of Birth
_____	_____
Signature of Partner	Date

For ***all*** Gestational Carrier candidates and for ***Directed*** Donor candidates (i.e. donor candidates personally known to recipients), please have partner (if applicable) complete a copy of this form

CLINICAL INFORMATION

I. CONTACT INFORMATION

Full Name:_____ Date of birth:_____
Address:_____
Phone number:_____ Email address:_____

II. DEMOGRAPHICS

Age:_____ Ethnicity:_____
Preferred pronoun(s):_____
Highest level of education completed:_____ Year:_____
Field of study (If applicable): _____
Additional training, certification, or licensure:_____ Year:_____
Occupation:_____ Employer:_____
Length of time with current employer:_____ Ever fired?_____

III. CURRENT RELATIONSHIPS/FAMILY INFORMATION

Relationship Status: ☐Single ☐Committed relationship ☐Married ☐Divorced ☐Widowed ☐Other
If in a committed relationship, how long in this relationship?_____ If married, what year:_____
Approximate dates of any prior marriages:_____
In addition to partner and/or children, does anyone else live with you?_____

List any biological children you have:

Child's Name	Child's Age	Child's Gender Identity	Name of Child's other Parent if not Current Partner	If other Parent is not Current Partner, Note Child Custody/Visitation Arrangements

Please indicate any pregnancies ending in miscarriage, stillbirth, or abortion:
_____

List any children your current partner has from prior relationships that live in your home part- or full time:

Child's Name	Child's Age	Child's Gender Identity	Child Custody/Visitation Arrangements

For either your own children or children of your partner who live in your home part- or full-time, please note any chronic medical issues or mental health concerns (including depression, anxiety, ADHD, eating disorders, Autism Spectrum Disorder, or substance abuse/addiction), developmental delays, learning disabilities, or significant emotional/behavioral difficulties:
_____

IV. FAMILY OF ORIGIN INFORMATION

Were your own biological parents married?_____ If not, did they live together?_____
If they were married or lived together, are they still married or living together?_____ If they separated/divorced, how old were you when they separated?____

How was custody/visitation handled?_____

Did either of your parents subsequently remarry or have a live-in partner?

_____

If either of your biological parents is deceased:

How old were you at the time?_____ What was the cause of death:_____

Please list your siblings below:

Sibling's Name	Sibling's Age	Sibling's Gender Identity	Full Sibling (Y/N)?	If Half- or Step-sibling, indicate maternal or paternal

V. History of Involvement in the Legal System

Please indicate below any history of arrests, noting the offense, approximate date(s)/age(s), and the outcome:

_____

VI. Substance Use History

Please indicate your current and historical use of substances below

	Current Use: Frequency & Amount	If No Current but Prior Use: Note Age/Dates	Any Use During Pregnancy or Difficulty Stopping during pregnancy?	Any Problem with Abuse or Addiction
Alcohol				
Tobacco				
Marijuana				
Other Recreational Drugs				

Please note any problems with abuse of or addiction to prescription drugs?

_____

Please note any significant negative outcomes due to personal substance use/abuse (i.e. DUII, physical fight, job loss):_____

VII. TRAUMA OR SIGNIFICANT LOSS-

In your home growing up, was there any drug or alcohol abuse or domestic violence?_____
If yes, please explain:_____

Did you experience any physical, emotional, sexual abuse/assault or other trauma in childhood?____
If yes, please explain:_____

Have you experienced any physical, emotional, sexual abuse/assault or other trauma as an adult?___
If yes, please explain:_____

Have you experienced any significant losses in childhood or adulthood?_____
If yes, please explain:_____

VIII. MENTAL HEALTH-

Note any ***PERSONAL HISTORY*** of mental health concerns or diagnoses, including depression or anxiety, alcoholism, drug abuse/addiction, eating disorders, ADHD, or learning disabilities:

Nature of Mental Health Concern	Age at Onset or Diagnosis	Situational Factors (If Applicable)	Counseling: Approximate Dates	Medications: Name of Med &Approximate Dates*	Other Coping or Lifestyle Approaches	Current Status of Symptoms

*Did you take any of these medications during a pregnancy ever?_____

Please note any counseling you have participated in not listed above:_____

Please note any hospitalization, inpatient treatment, or intensive outpatient treatment for mental health reasons (alcohol/drug problems or eating disorders):
_____

Have you ever engaged in self-harm behavior, not for the purpose of trying to end your life?_____
If so, please explain:_____

Have you ever been suicidal?____ If so:
Did you make a plan for ending your life?____ If so, did you take any steps to initiate the plan?_____
Have you ever been admitted to a hospital or inpatient unit for suicidal ideation or attempt?_____

Among your ***GENETIC RELATIVES***, **INCLUDING EXTENDED FAMILY MEMBERS**, please note any history of mental health problems or diagnoses, including depression, anxiety, alcoholism, drug abuse/addiction, eating disorders, ADHD, or learning disabilities:

Family Member	Nature of Mental Health Concern	Situational Factors (If Applicable)	Age at Onset or Diagnosis	Counseling Ever (Y/N)?	Medications Ever (Y/N)?