The Reproductive Medicine Group
INFERTILITY • REPRODUCTIVE ENDOCRINOLOGY • IVF

Signature Page – Informed Consent for Assisted Reproduction

Account # _____

Patient: _____ Partner:_____ Date: _____
Print Name *Print Name*

PLEASE READ THIS FORM CAREFULLY

It is policy of The Reproductive Medicine Group to treat both the patient and the spouse/partner as a couple. Both the patient and spouse/partner, together, must agree and consent to an intended treatment plan. Once mutually agreed upon, it is expected that the treatment plan will proceed as intended unless extenuating circumstances arise. Any requested changes to the intended treatment plan, by either party, must be disclosed to each other and agreed upon, in writing, by both parties and by The Reproductive Medicine Group.

These pages are to be signed in the presence of RMG staff or physicians.
Check each item that applies. Sign and date each section.

ACKNOWLEDGMENT OF INFORMED CONSENT

☐ I/We acknowledge receiving, reading, and initialing the 21 page Informed Consent for Assisted Reproduction: In Vitro Fertilization, Intracytoplasmic Sperm Injection, Assisted Hatching and Embryo Freezing on _____. I/We have provided the opportunity to review the Informed Consent document today in preparation for the upcoming procedure. I/We were given the opportunity to ask questions. All questions were satisfactorily answered prior to signing this Signature page for Informed Consent.

Patient Partner Date

_____ _____ ____/____/_____

GAMETE/EMBRYO DISPOSAL

Any sperm, eggs or embryos which The Reproductive Medicine Group IVF Program, your treating physicians or other professionals who work at The Reproductive Medicine Group IVF Program believe are nonviable, chromosomally and/or genetically abnormal, or otherwise medically unsuitable for use in ART Procedures will be discarded or used for scientific research or educational purposes in accordance with The Reproductive Medicine Group IVF Program's practices and procedures.

☐ I/We hereby CONSENT to allow the RMG ART Laboratory to utilize my/our immature or unfertilized eggs and my/our left-over sperm for quality control and training purposes before they are disposed.

☐ I/We hereby DO NOT CONSENT to allow the RMG ART Laboratory to utilize my/our immature or unfertilized eggs, or left-over sperm for quality control and training purposes. This material will be disposed in accordance with normal laboratory procedures and applicable laws.

☐ I/We hereby CONSENT to allow the RMG ART Laboratory to utilize my/our abnormal or discarded embryos for quality control and training purposes before they are disposed.

☐ I/We hereby DO NOT CONSENT to allow the RMG ART Laboratory to utilize my/our abnormal or discarded embryos for quality control and training purposes. This material will be disposed in accordance with normal laboratory procedures and applicable laws.

Patient Partner Date

_____ _____ ____/____/_____

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EMBRYO TRANSFER

We (I) understand that the embryo quality at the time of transfer may modify the number of embryos that will be transferred. The number that you will indicate below is the maximum number to transfer. This number to transfer may be reduced depending on age category. Exceptions will be documented on the signature page with your signature and that of your physician.

We (I) agree to insemination of all eggs and transfer a limit of _____ embryos on day 5 or 6. Our/my physician has not recommended transfer of more than a limit of _____ embryos on day 5. We/I understand that there is an additional increased risk of multiple pregnancy should we/I choose to have more than the recommended number transferred

Patient	Partner	Date
_____	_____	_____/_____/_____

ELECTIVE SINGLE EMBRYO TRANSFER

Women 34 years or younger or women who are using donor eggs.

☐ We/I elect to proceed with elective single embryo transfer if we/I have two or more grade one (1) embryos on day five (5) for embryo transfer.

☐ We/I elect NOT to proceed with single embryo transfer. We/I acknowledge the preceding conditions and risks of having a multiple pregnancy. We/I have read and understand the Elective Single Embryo Fact Sheet with the tables for single versus multiple pregnancy risk.

Patient	Partner	Date
_____	_____	_____/_____/_____

EMBRYO FREEZING AND DISPOSITION

☐ We/I authorize cryopreservation (freezing) of all (one or more) Grade I or Grade II embryos deemed cryopreservable which are not transferred (as fresh embryos) during the ART procedures.

☐ We/I elect to cryopreserve only if there is/are ___or more embryos available for cryopreservation. If that minimum embryo number is not available I/we elect to dispose of the remaining embryos.

☐ We/I elect NOT to cryopreserve embryos.

Patient	Partner	Date
_____	_____	_____/_____/_____

The RMG ART Laboratory will maintain cryopreserved embryos for a period of one year after freezing with this consent. The subsequent year's storage fee (fee schedule available by request) for the continuation of cryopreserved embryo storage is expected to be paid prior to start of the second year and each subsequent year that your embryos are stored with RMG ART Laboratory. The fee will be applicable for all or any part of the year's storage. If you do not wish to continue storing the cryopreserved embryos, they may be:

1) thawed and transferred to your uterus (or surrogate uterus) by your consent;
*2) donated to another person or couple or to an agency by your consent and if arranged by you in consultation with RMG;
3) donated to research or for quality control by your consent;
4) disposed by your consent; or
*5) transferred to another storage facility if arranged and paid for by you

*(*you may be asked to undergo additional infectious disease testing and screening recommended by the FDA if you select this option)*

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NOT ALL CRYOPRESERVATION DISPOSAL OPTIONS ARE AVAILABLE FOR ALL CIRCUMSTANCES

If any cryopreserved embryos are not transferred, discarded, donated or sent by arrangement to another storage facility at one (1) year from the date of freezing and if payment for the care and storage of the embryos is not made for the following year or ceases for a period of six consecutive months after notice of nonpayment; or the RMG ART Laboratory IVF Program is unable after reasonable time and effort to contact us, the embryo(s) will be considered abandoned. The Reproductive Medicine Group IVF Program is then expressly hereby authorized to dispose at that time or later, all the cryopreserved embryos held by the RMG ART Laboratory in accordance with normal laboratory procedures and applicable law, as indicated below. Such disposition may include and we elect to:

☐ Thaw and discard the embryo(s)

☐ Donate the embryo(s) for research or for quality control

Patient	Partner	Date
_____	_____	____/____/_____

DEATH OR INCAPACITATION

In the event of death or incapacitation of both partners or of a last surviving partner, in the absence of a legal directive disposing the embryo(s), the embryo(s) will be disposed of by the RMG ART Laboratory. In this event, I/we elect to:

☐ Thaw and dispose the embryo(s) _____ *Patient Initials* _____ *Partner Initials*

☐ Donate the embryo(s) for research or for quality control _____ *Patient Initials* _____ *Partner Initials*

NOTE: A legal directive disposing the embryo(s) will take precedent over this consent. An option to donate the embryo(s) to another person or couple, or frozen embryo(s) donation service or agency may be considered. Please notify RMG if or when a legal directive is created that may change your embryo(s) disposition election of either thawing and disposing of the embryo(s) or donating the embryo(s) for research or for quality control.

No guarantees can be given that embryo(s) will be used for research or for quality control or donated to another couple. In these instances, if after 2 years a recipient or a research/quality control project can not be found, or if your embryos are not deemed eligible, your embryo(s) will be disposed by the RMG ART Laboratory in accordance with laboratory procedures and applicable laws.

Patient	Partner	Date
_____	_____	____/____/_____

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ART PROCEDURES

Please **place your signatures below** to indicate which components of IVF treatment you agree to undertake in your upcoming treatment cycle.

ART PROCEDURE	Patient Signature	Partner Signature	Date
☐ In Vitro Fertilization (IVF) (egg retrieval and embryo transfer-ET)	_____	_____	_____
☐ Intra-cytoplasmic Sperm Injection (ICSI)	_____	_____	_____
☐ Assisted Hatching	_____	_____	_____
☐ Embryo Cryopreservation	_____	_____	_____
☐ Donor egg with IVF/ET	_____	_____	_____
☐ Gestational Surrogate with IVF/ET	_____	_____	_____
☐ PGT-A ☐ PGT-SR ☐ PGT-M	_____	_____	_____
Other			
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

_____

_____

_____

_____ _____ _____ _____
Patient Signature *Date* *Partner Signature* *Date*

_____ _____ _____
Witness to Signature *Printed Name* *Date*

I have consulted with and explained the contents of the Informed Consent for Assisted Reproduction to the couple/individual who have signed above.

_____ _____ _____
Physician Signature *Printed Name* *Date*

Account # _____