



Consent to Thaw Cryopreserved Embryo(s) and Consent for Embryo Transfer

Print Patient's Name

SS#

Print Partner's Name

SS#

We (I), the undersigned, request, authorize and consent to the thawing and utilization of cryopreserved (frozen) embryos stored by Women's Fertility Center and as appropriate, its employees, contractors, and consultants and authorized agents for us.

We (I) understand that there is no guarantee that any of the embryos will survive the thawing process. Furthermore, we (I) understand also that there is no guarantee that the transfer of the thawed embryos will result in a conception. We (I) understand and consent that the number of embryos thawed is at the discretion of the Women's Fertility Center staff in consultation with us (me). Furthermore, the number of embryos thawed will be determined by the embryo quality and number at freezing and thawing, the age of female, the medical conditions leading to our (my) infertility and our (my) choice in consultation with our (my) physician. We (I) also understand and agree that the Women's Fertility Center staff may perform selective assisted hatching on these embryos, if needed.

We (I) understand that, just as was the case with our (my) initial cycle of IVF using fresh embryos, the transfer of more than one embryo into the uterus may result in a multiple pregnancy. We (I) understand that multiple pregnancy is associated with an increased risk of miscarriage and premature birth. In the case of a premature birth, the resulting children may not survive or if they do survive, they may experience significant long-term health problems associated with their premature delivery.

We (I) understand that the process of utilizing the frozen/thawed embryos may require the use of hormones and monitoring using ultrasound and blood tests to determine the optimal time to perform the embryo transfer and to support the function of the uterine lining after transfer. The process also involves an embryo transfer as described in the IVF Consent that we have previously signed.

Consent for Thaw of Cryopreserved Embryo(s) & Embryo Transfer



We (I) acknowledge that thawing and utilization of cryopreserved embryos is being performed at our (my) request and is purely voluntary. We (I) understand that we (I) may withdraw my consent at any time and that my present or future care will not in any way be affected by my decision.

We agree with the plan that embryos will be thawed until the agreed upon planned number of embryos for transfer has been reached. We understand that it may require that all cryopreserved embryos in storage be thawed in order to reach this number (i.e., the embryologists will continue to thaw embryos until the planned number of embryos for transfer has been achieved).

Note:

We understand that we currently have ____ embryos frozen at the
(check one) ____ day 3 ____ blastocyst stage.

We consent to thaw ____ embryos to enable us to transfer ____ embryos at the
(check one) ____ day 3 ____ blastocyst stage.

We (I) acknowledge that this consent must be signed by the same individual(s) who executed the original cryopreservation consent. We (I) understand, agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

Signature of Patient

Date

Signature of Witness

Date

Signature of Partner

Date

Signature of Witness

Date

This consent has been read by and discussed with the patient and partner, where applicable.

Signature of Nora Miller, MD

Date