Assisted Reproduction: In Vitro Fertilization, Intracytoplasmic Sperm Injection, and Assisted Hatching Consent

Please read the following consent carefully. If you do not understand the information provided, please speak with your treating physician or nurse. After reading this consent, you will be asked to make several decisions regarding the elements of IVF treatment you agree to undertake in your upcoming IVF treatment cycle.

This consent must be signed by both partners (if applicable) with PICTURE IDs in the presence of a Arizona Reproductive Medicine Specialists (ARMS) nurse. All sections of the signature consent, pages 1-4, must be completed. These signature pages will be maintained at ARMS. If you and/or your partner are unable to sign the consent in the presence of an ARMS nurse, the consent must be notarized and pages 1-4, plus the notary page, page 5, returned to and maintained at ARMS. You should keep the rest of the consent for your records.

Printed Name:
________________________________               ________________________________
Female Patient                                                   Partner (if applicable)

ARMS MPI Number:
________________________________  _______________________________
Female Patient                                                            Partner (if applicable)

ARMS Nurse completing above information:
________________________________     _______/_______/________________
Signature     Date provided to patient
Components of IVF Treatment

Please CHECK AND BOTH SIGN EACH SECTION below to indicate your decisions regarding the elements of IVF treatment you agree to undertake in your upcoming IVF treatment cycle.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
|     |    | In-Vitro Fertilization - including egg retrieval and embryo transfer

_______________________________                        _______________________________
Female Patient                                                             Partner (if applicable)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
|     |    | Intracytoplasmic Sperm Injection when the semen analysis is abnormal - To ensure that you have the best options available for pregnancy in your IVF cycle, the ARMS medical team recommends that you check “Yes” and sign here for Intracytoplasmic Sperm Injection (ICSI). In most circumstances, the medical indications for the use of ICSI are anticipated and it’s indications for use in your care will have been discussed with you. However, at times, based on the embryology laboratory view of the sperm and/or eggs the day of the egg retrieval or day after, the unanticipated use of ICSI to aid fertilization may be warranted. If the ICSI consent has not been checked “Yes” and signed, the addition of the ICSI to improve your chances of pregnancy in the cycle cannot be done.

_______________________________                        _______________________________
Female Patient                                                             Partner (if applicable)
Intracytoplasmic Sperm Injection when the semen analysis is normal - As stated in the previously presented information, when the semen analysis is determined to be normal, 93% of the time the eggs fertilize normally. However, 7% of the time there is complete failed fertilization. When this occurs, there is no chance of conception if nothing is done because there will be no embryos to transfer. When there is low or no fertilization seen the day after the egg retrieval, the embryologist can perform “Rescue ICSI”. Rescue ICSI is the process of performing ICSI the day after the egg retrieval on unfertilized eggs when low or no fertilization has occurred. Though pregnancies have occurred from this procedure, success rates are much lower than when the eggs fertilize from the initial exposure to sperm. Some clinics elect to perform ICSI on all of the eggs, even if the sperm is normal. This approach means that 93% of patients will have an expensive procedure performed that was not necessary and may harm some eggs in order to prevent 7% of patients from having a poor outcome due to low or no fertilization after conventional insemination of the oocytes. Check “yes” in this section if you want ICSI performed **even though your semen analysis is normal**. You will need to pay for this procedure before it will be done. Check “No” **if you do not want ICSI performed after being informed that your semen analysis is normal**. If at this point you do not know the result of your semen analysis, ask the staff to bring you a written copy now. Checking “No” indicates that you will not have ICSI performed and will not incur the costs of ICSI if fertilization is normal and Rescue ICSI is not done. Checking “No” also indicates that you fully accept all of the negative consequences of low or no fertilization including but not limited to a failed IVF cycle and the need to incur ALL of the financial, physical, and emotional consequences of having to do another IVF cycle. This means that you will need to incur ALL of the same costs you incurred with the first IVF cycle including clinic charges, medication costs and all other costs associated with the first cycle that failed. Checking “Yes” OR “No” also means that you have been informed of the results of the latest semen analysis that has been performed and that the results were reported as normal.

I understand that if ICSI has been recommended in our case, that it is recommended that blood be drawn on the male partner and sent for a karyotype and a Y microdeletion analysis and that it is our responsibility to see that this is done. We also understand that if either of these tests is abnormal, that it is recommended that we receive formal genetic counseling. We further understand that it is our responsibility to see that this is done.
Yes  No

_____  _____  Assisted Hatching - To ensure that you have the best options available for pregnancy in your IVF cycle, the ARMS medical team recommends that you check “Yes” and sign here for Assisted Hatching (AH).

_______________________________                        _______________________________
Female Patient                                                             Partner (if applicable)

Quality Control for In-Vitro Fertilization and Embryo Culture (refer to Section A-1-c, page 6)
Quality control in the lab is extremely important. Sometimes immature or unfertilized eggs, sperm or abnormal embryos (abnormally fertilized eggs or embryos whose lack of development indicates they are not of sufficient quality to be transferred) that would normally be discarded can be used for quality control. You are being asked to allow the clinic to use this material for quality control purposes before being discarded in accordance with normal laboratory procedures and applicable laws. None of this material will be utilized to establish a pregnancy or a cell line unless you sign other consent forms to allow the clinic to use your eggs, sperm or embryos for research purposes. (Please select one option.)

I/We hereby **CONSENT** to allow the clinic to utilize my/our immature or unfertilized eggs, left-over sperm or abnormal embryos for quality control and training purposes before they are discarded.

_______________________________                        _______________________________
Female Patient                                                             Partner (if applicable)

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

_______________________________                        _______________________________
Female Patient                                                             Partner (if applicable)
Assisted Reproduction Exempt Status for Donor Screening

New FDA regulations which govern the screening of donors of reproductive tissues state that a donor is exempt from infectious disease screening if the donor is sexually intimate with the recipient. Your signature below indicates that you attest that you are sexually intimate with the sperm donor (husband).

__________________________
Date

__________________________
Patient’s Signature

__________________________
Date

__________________________
Witness’s Signature
ACKNOWLEDGEMENT

I/We have been fully advised of the purpose, risks and benefits of each of the procedures indicated above, as well as Assisted Reproduction generally, and have been informed of the available alternatives and risks and benefits of such alternatives. This information has been supplemented by my/our consultation with my/our medical team. I/We have had the opportunity to ask questions and all my/our questions have been answered to my/our satisfaction.

I/We have read the Patient Guide and the Assisted Reproduction document in their entirety and have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction services as stated above.

________________________________               ________________________________
Signature - Female Patient                               Signature - Partner (if applicable)

_______/_______/______________  ________/_______/______________
Date                                                                              Date

Type of Picture Identification

Drivers License # __________________________
Expiration Date: ______/_____/_______

Passport #: _______________________________
Expiration Date: ______/_____/_______

Other: _________________________________
Expiration Date: ______/_____/_______

Picture Identification(s) Confirmed on Date:
_______/_______/________________

Witness - Print Name and Title

____________________________
Witness – Signature

Type of Picture Identification

Drivers License # __________________________
Expiration Date: ______/_____/_______

Passport #: _______________________________
Expiration Date: ______/_____/_______

Other: _________________________________
Expiration Date: ______/_____/_______

Picture Identification(s) Confirmed on Date:
_______/_______/________________

Witness - Print Name and Title

____________________________
Witness – Signature
Consents signed outside the Practice must be notarized and dated.

Female Partner
State of __________
County of __________
I certify that I know or have satisfactory evidence that ________________________ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.
Dated __________________ Notary Signature
____________________________________

Title
My appointment expires: _______________

Partner
State of __________
County of __________
I certify that I know or have satisfactory evidence that ________________________ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.
Dated __________________ Notary Signature
____________________________________

Title
My appointment expires: _______________