Northwestern Medicine®
Center for Fertility and Reproductive Medicine

CHICAGO OFFICE:
259 EAST ERIE STREET
SUITE 2400
CHICAGO, IL 60611
OFFICE: 312.695.7269
FAX: 312.695.4924

HIGHLAND PARK OFFICE:
600 CENTRAL AVENUE
SUITE 333
HIGHLAND PARK, IL 60035
OFFICE: 847.535.8700
FAX: 847.535.6999

OAKBROOK TERRACE OFFICE:
2 TRANS AM PLAZA
SUITE 400
OAKBROOK TERRACE, IL 60181
OFFICE: 630.545.3766
FAX: 630.933.7392

CONSENT FOR OOCYTE THAW/EMBRYO TRANSFER

Patient: _____
Last Name First Name Middle Initial Date of Birth

Partner: _____
(If Applicable) Last Name First Name Middle Initial Date of Birth

I/We consent to the performance of the following procedure upon the patient named above:

Name of Procedure: ❑ Oocyte Thaw Transfer ❑ Zygote Thaw Transfer ❑ Embryo Thaw Transfer ❑ Blast Thaw Transfer

1. I understand that a number of individual procedures may be required in order to perform the procedure named above, such as blood transfusions, medications and other therapies. My consent to the procedure named above is also an authorization for these procedures, unless an exception is noted. _____
   State exception, if any, or NONE.
2. If any presently unknown conditions are revealed in the course of the procedure named above which call for different or further procedures, I hereby consent to and authorize the performance of such procedures upon the patient named above.
3. Dr. _____, the attending physician(s) will perform and/or supervise the performance of this procedure. I authorize the physician performing this procedure to obtain the assistance of other physicians (including residents and interns), as he/she considers advisable. In addition, I authorize the physician performing this procedure or assisting physician to administer anesthesia to the patient named above as required during the course of the procedure.
4. For the purpose of advancing medical education, I consent to observation of this procedure by qualified observers (including medical and nursing students). I also authorize NMG and its agents, employees and physicians to take pictures during the procedure and publish the pictures in scientific journals and exhibit them for educational purposes, providing that the identity of the above named patient is not revealed. If the patient's identity would be revealed by publication of the pictures or accompanying text, they will not be published unless I specifically agree to this in writing. In addition, I authorize NMG to retain any specimens or tissues taken from the patient's body for research or teaching purposes.
5. A physician has explained the procedure to me and informed me of the risks involved in the procedure and the risks involved if I do not undergo this procedure. I was also informed of possible alternative methods of treatment, and of the risks involved in these alternative methods. I have had an opportunity to discuss this procedure with a physician, and have received answers to all questions I have asked.
6. The possible outcomes of this procedure have been explained to me, and I understand there is **NO GUARANTEE** that any particular results will be obtained.

I/We have read and understand all the sections of this consent form. All the blank spaces were filled in before I signed the form. If any items were stricken from the printed form or from any handwritten items, my initials were placed next to the stricken items before I signed the form. If I change my mind, I must notify the physician immediately.

KNOWN ALLERGIES: _____

PATIENT & PARTNER (IF APPLICABLE) SIGNATURE(S):

_____
PATIENT NAME – PRINT **PATIENT SIGNATURE** **DATE**

Notary Name (PRINT): _____
Notary City/State: _____
Notary Signature: _____
Date: _____

NOTARY STAMP:

_____
PARTNER NAME – PRINT (IF APPLICABLE) **PARTNER SIGNATURE** **DATE**

Notary Name (PRINT: _____
Notary City/State: _____
Notary Signature: _____
Date: _____

NOTARY STAMP:

OFFICE WITNESS (IF NOT SIGNED IN FRONT OF PHYSICIAN OR NOTARY):

_____
Office Staff Name – PRINT Title Signature Date