



Fertility and Reproductive Medicine

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Patient MRN: _____

SUMMARY OF IVF CONSENT

I/We have read the information attached in the "Informed Consent for Assisted Reproduction." I/We have had adequate time to review the information and are ready to begin an IVF Treatment Cycle. My/our questions have been satisfactorily answered and I agree to undergo the IVF procedure.

Patient Name – Please PRINT Patient Signature Date of Birth Date

Partner Name (If Applicable) – Please PRINT Partner Signature Date of Birth Date

Physician Name – Please PRINT Physician Signature Date

IVF SPECIFIC REQUESTS

Please select ONE:

I authorize NMG to Cryopreserve (freeze) any viable embryos in excess of those transferred and agree to pay additional fees for freezing and storing my embryos. Patient Initials Partner Initials

I do NOT authorize NMG to Cryopreserve (freeze) any viable embryos in excess of those transferred. Patient Initials Partner Initials

If embryos have been cryopreserved and death or incapacitation occurs, you agree to ONE of the following:

Thaw and discard the embryos Patient Initials Partner Initials

Donate the embryos for research Patient Initials Partner Initials

Donate the embryos to another couple Patient Initials Partner Initials

Do you authorize NMG to carry out the following procedures if, in the opinion of your physician and/or laboratory staff, this will significantly increase the chance of pregnancy, and agree to pay additional fees for the procedure?

1. Intracytoplasmic Sperm Injection (ICSI) Yes No Patient Initials Partner Initials

2. Assisted Hatching Yes No Patient Initials Partner Initials