Northwestern Medicine®

PATIENT LABEL

OOCYTE/EMBRYO THAW INFORMATION AND CONSENT

Intended Parent A: Name _____ Date of birth _____

Intended Parent B: Name _____ Date of birth _____

I/we understand that the laboratory team at Northwestern Medicine Center for Fertility and Reproductive Medicine will thaw my/our oocyte(s)/embryo(s). We know that thawing involves the use of some or all of the following procedures.

- **Oocyte thawing:** The thawing of frozen oocyte(s) and the removal of the cryoprotectants.
- **Intracytoplasmic sperm injection** (ICSI): Injection of sperm into an oocyte for the purposes of fertilization.
- **Embryo thawing:** The thawing of frozen embryo(s) and the removal of the cryoprotectants.
- **Assisted zona hatching:** A technique in which a small hole is made in the zona pellucida (a shell around the embryo) before transfer to aid implantation.

My/our physician and the laboratory team will decide which procedures to use.

Laboratory Risks

Freezing, storing, and thawing oocyte(s)/embryo(s) is complex. Not all oocyte(s)/embryo(s) will successfully thaw. Upon thawing, oocyte(s)/embryo(s) may be damaged, destroyed or lost, or fail to develop. This would make them unavailable for further treatment or implantation. Reasons for this could include, but are not limited to:

- Oocyte/embryo-specific differences in tolerance of freezing
- Accidents
- Power outages
- Mechanical or equipment failure (including but not limited to loss of nitrogen or other tank failures)
- Materials (including vials, straws and other devices used to freeze and store the samples and their labels)
- Human error
- Labelling errors
- Natural disasters
- Transportation or shipping accidents
- Other events that may be beyond the control of Northwestern Medicine or its laboratory

In some cases, Northwestern Medicine may not own or operate the laboratory responsible for freezing or previous storage of your oocyte(s)/embryo(s). You cannot hold them responsible for laboratory processes beyond their knowledge and control.

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Intended Parent A: Name _____ Date of birth _____

Intended Parent B: Name _____ Date of birth _____

AGREEMENT AND CONSENT

1. I/We voluntarily choose to participate in the thawing of oocyte/embryo.
2. I/We each acknowledge and agree that my/our acceptance of treatment at Northwestern Medicine Center for Fertility and Reproductive Medicine and our continued participation is at the discretion of Northwestern Medicine. It depends upon whether I/we follow the Center for Fertility and Reproductive Medicine's policies and procedures.
3. Whether any oocyte(s)/embryo(s) can survive freezing and thawing depends upon the quality of the oocyte/embryo before it is frozen. No one can predict survival of oocyte(s)/embryo(s) and the development of suitable embryo(s) for transfer. I/We understand that freezing and thawing may damage the oocyte(s)/embryo(s). This could include damage to embryonic reproductive cells, loss of some embryonic cells, and/or loss of viability of the embryo as a whole. I/We know that our choice of how many oocyte(s)/embryo(s) to thaw may not result in the number of oocyte(s)/embryo(s) we wish to have transferred during the Frozen Embryo Transfer (FET).
4. I/We understand Northwestern Medicine **does not guarantee** any particular results.
5. I/We understand and agree that if the embryologists and physicians at Northwestern Medicine Center for Fertility and Reproductive Medicine use reasonable medical judgment to determine that any of my/our oocyte(s)/embryo(s) are non-viable or embryo(s) are not medically suitable for transfer, Northwestern Medicine will dispose of those oocyte(s)/embryo(s) in an ethically acceptable manner. Northwestern Medicine will follow the Center for Fertility and Reproductive Medicine's policies and the American Society for Reproductive Medicine Ethical Standards for disposal. I/We consent to such disposition in the circumstances described.
6. I/We understand that the Fertility Clinic Success Rate and Certification Act was passed in 1992. This law requires the Centers for Disease Control and Prevention (CDC) to gather information about In vitro Fertiization (IVF) cycles and pregnancy outcomes in the U.S. each year. The government uses this information to calculate success rates, which are reported each year. I/We know that the Center for Fertility and Reproductive Medicine will report the required information from my/our IVF procedure to the CDC. As a member of the Society of Assisted Reproductive Technologies (SART) of the American Society for Reproductive Medicine (ASRM), the Center for Fertility and Reproductive Medicine will also report this information to SART. I/We know that information reported to SART about my/our cycle may be used for research or quality assessment according to HIPAA guidelines. My/Our name(s) will never be connected to my/our cycle information in any research published by ASRM or SART.

OOCYTE/EMBRYO THAW INFORMED CONSENT

By signing below, I/We agree that we have read and understand the information on this form. I/We understand the risks of oocyte/embryo thawing described above. All of my/our questions have been answered. I/We consent to all procedures outlined on this form.

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OOCYTE/EMBRYO THAW
INFORMATION AND CONSENT

Intended Parent A

Last Name _____ First Name_____

Date of Birth _____

_____,

Time Date Intended Parent A Signature

Notary Public

Subscribed and sworn to (or affirmed) before me on this day _____ of _____ , 20_____.

Proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

_____,

Time Date Notary Signature

Notary Seal or Stamp

Intended Parent B

Last Name _____ First Name_____

Date of Birth _____

_____,

Time Date Intended Parent A Signature

Notary Public

Subscribed and sworn to (or affirmed) before me on this day _____ of _____ , 20_____.

Proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

_____,

Time Date Notary Signature

Notary Seal or Stamp

If signed in office: **Statement by Witness (must be Fertility and Reproductive Medicine employee)**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Time _____ Date _____ Witness Signature_____

Print Name _____