

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 If the patient's identity would be revealed by publication of the pictures or accompanying text, they will not be published unless I specifically agree to this in writing.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