Northwestern Medicine®
Fertility and Reproductive Medicine

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OFFICE: 847.535.8700 **FAX**: 847.535.6999

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