



**CONSENT FOR ASSISTED REPRODUCTION**  
*In Vitro Fertilization, Intracytoplasmic Sperm Injection,  
Assisted Hatching, Embryo Freezing and Disposition*

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Please read the following consent carefully. If you do not understand the information provided, please speak with your treating physician or nurse.

This consent must be signed by both partners (if applicable) with **PICTURE IDs** in the presence of a Seattle Reproductive Medicine (SRM) staff member. All sections of the consent must be completed. These signature pages will be maintained at SRM and will remain in effect indefinitely unless you execute a new consent form to replace it—this may be done any time at your request. If you and/or your partner are unable to sign the consent in the presence of a SRM staff member, the consent must be **notarized** and the notary page returned to and maintained at SRM. You should keep a copy of the consent for your records.

**Printed Name:**

\_\_\_\_\_  
**Female Patient**

\_\_\_\_\_  
**Partner (if applicable)**

**SRM MPI (Identification) Number:**

\_\_\_\_\_  
**Female Patient**

\_\_\_\_\_  
**Partner (if applicable)**

**SRM employee completing above information:**

\_\_\_\_\_  
**Printed name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date provided to the patient**

## Consent for IVF Treatment

Please **CHECK AND SIGN (BOTH PARTNERS) EACH SECTION** below to indicate your decisions regarding the elements of IVF treatment you agree to undertake in your upcoming IVF treatment.

Yes No

\_\_\_\_\_ **In-Vitro Fertilization** - Including ovarian stimulation, egg retrieval, insemination of eggs, embryo culture, and embryo transfer. ***/we understand that the physicians at SRM reserve the right to limit the number of embryos transferred to the maximum recommended by the American Society of Reproductive Medicine as outlined in "Assisted Reproduction Patient Information".***

The actual number will be determined as discussed with my/our primary physician depending on the quality and developmental stage of available embryos.

Unless otherwise specified, all mature oocytes will be inseminated. If you do not consent to either cryopreservation or discarding of fertilized eggs (embryos), then the number inseminated will be limited to no more than the maximum number of embryos to be transferred to the uterus. We agree that \_\_\_\_\_ all or no more than \_\_\_\_\_ eggs will be inseminated with sperm from \_\_\_\_\_ partner or \_\_\_\_\_ sperm donor. Any oocytes not cryopreserved or inseminated with sperm according to the instructions above will be discarded in accordance with acceptable laboratory practices.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

Yes No

\_\_\_\_\_ **Intracytoplasmic Sperm Injection** - To ensure that you have the best options available for pregnancy in your IVF cycle, the SRM medical team recommends that you check "Yes" and sign here for Intracytoplasmic Sperm Injection (ICSI). In most cases, the medical indications for the use of ICSI are anticipated and its indications for use in your care will have been discussed with you. However, at times, based on the embryology laboratory assessment of the sperm and/or eggs on the day of the egg retrieval or day after, the *unanticipated* use of ICSI to aid fertilization may be warranted. If the ICSI consent has not been checked "Yes" and signed, the addition of the ICSI to improve your chances of pregnancy in the cycle cannot be done.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

Yes No

\_\_\_\_\_ **Assisted Hatching** - To ensure that you have the best options available for pregnancy in your IVF cycle, the SRM medical team recommends that you check "Yes" and sign here for Assisted Hatching (AH). In most circumstances, the medical indications for the use of AH are anticipated and its indications for use in your care will have been discussed with you. However, at times, based on the embryology laboratory assessment of the embryos the day of the embryo transfer, the *unanticipated* use of AH to aid implantation may be warranted. If the AH consent has not been checked "Yes" and signed the addition of the AH to improve your chances of pregnancy in the cycle cannot be done.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

Yes No

\_\_\_\_\_ **Embryo Cryopreservation** of viable, high quality embryos (if any) not transferred. I understand that if I do not elect to freeze embryos, all embryos not transferred to the uterus will be discarded according to routine laboratory procedures. I understand that embryo freezing/storage carries a risk of loss of the embryos due to the freeze/thaw process, mechanical failure, or natural disaster.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

Yes No

\_\_\_\_\_ **Quality Control Use of Eggs, Sperm and Embryos Prior to Discarding –** Sometimes immature or unfertilized eggs, sperm or abnormal embryos (abnormally fertilized eggs or embryos whose lack of development indicates they are not of sufficient quality to be transferred) that would normally be discarded can be used for quality control. You are being asked to allow SRM to use this material for quality control purposes. None of this material will be utilized to establish a pregnancy or a stem cell line.

Please check yes if you consent to the use of immature/unfertilized eggs, left-over sperm, or abnormal embryos for quality control and training purposes before they are discarded. If you check no, they will be discarded after no more than three days, in accordance with standard laboratory procedures.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

**Disposition of Abandoned Cryopreserved Embryos –** The law is unclear regarding when embryos are considered to be abandoned. However, SRM follows the guidelines issued by the American Society of Reproductive Medicine (ASRM). I/we understand that in the event that 1) there is no contact with the clinic for a period of five (5) years and the clinic is unable to contact either partner after reasonable efforts have been made, **or** 2) if fees associated with embryo storage have not been paid for a period of five (5) years, the embryo(s) will be considered to be abandoned and may be destroyed and discarded by SRM in accordance with standard laboratory procedures and applicable law.

\_\_\_\_\_  
Signature, Female Patient

\_\_\_\_\_  
Signature, Partner (if applicable)

**Disposition of Cryopreserved Embryos** – Any disposition of embryos requires the written authorization of both partners. If your embryos were formed using eggs or sperm from a third party donor, your instructions to donate these embryos must be in accordance with prior agreements with the gamete donors or applicable law. Your instructions to donate the embryos may require separate consent from the gamete donor.

I/We understand and agree that in the event of death or incapacitation on one partner, the embryo(s) will become the sole and exclusive property of the surviving partner, unless otherwise directed by law, a court order or as designated in my will. If you wish to have a child conceived after your death, you will need to seek legal counsel in order to execute a legal document indicating your intent.

In the event of divorce or dissolution of the relationship between patient and partner, embryos cannot be used without the express, written consent of both parties or as directed by a court order, even if donor gametes were used.

I/We understand that SRM will only maintain cryopreserved embryos for a period of five (5) years or until the female patient reaches fifty-one (51) years of age. Before that date, the cryopreserved embryos, if any, must be: 1) thawed and transferred for the purposes of establishing a pregnancy; 2) donated to research; 3) discarded; 4) donated to another patient, or 5) transferred to another storage facility for long-term storage. If no disposition has occurred before the female's 51<sup>st</sup> birth date, I/we hereby waive any and all interest in said cryopreserved embryo(s), and agree to the disposition outlined in this consent form, below.

I/We understand that we are free to revise the choice indicated below at any time by completing another form and having our signatures notarized.

<b>Discard the cryopreserved embryo(s)</b>	_____	_____
	Female Patient	Partner (if applicable)
OR		
<b>Donate the embryo(s) for research</b>	_____	_____
	Female Patient	Partner (if applicable)
OR		
<b>Donate the embryo(s) to another patient</b>	_____	_____
	Female Patient	Partner (if applicable)
OR		
<b>Transfer the embryo(s) to another facility for long-term storage</b>	_____	_____
	Female Patient	Partner (if applicable)

**Default Disposition—***I/We understand and agree that in the event none of our elected choices are available, as determined by the clinic, SRM is authorized without further notice to us, to destroy and discard our embryos.*

\_\_\_\_\_  
Signature, female patient

\_\_\_\_\_  
Signature, partner (if applicable)

**ACKNOWLEDGEMENT**

I/We have been fully advised of the purpose, risks and benefits of each of the procedures indicated above, as well as Assisted Reproduction generally, and have been informed of the available alternatives and risks and benefits of such alternatives. This information has been supplemented by my/our consultation with my/our medical team. I/We have had the opportunity to ask questions and all my/our questions have been answered to my/our satisfaction.

I/We have read the “**Assisted Reproduction Patient Information**” (Consent ID 35) document in its entirety and have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction services as stated above.

<p>_____ <b>Signature - Female Patient</b></p> <p>_____/_____/_____ <b>Date</b></p>	<p>_____ <b>Signature - Partner (if applicable)</b></p> <p>_____/_____/_____ <b>Date</b></p>
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**Type of Picture Identification**

**Female Patient:**

\_\_\_\_ Drivers License    \_\_\_\_ Passport    \_\_\_\_ Other \_\_\_\_\_

**Partner (if applicable):**

\_\_\_\_ Drivers License    \_\_\_\_ Passport    \_\_\_\_ Other \_\_\_\_\_

Picture Identification(s) Confirmed on Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_  
**Witness - Print Name and Title**

\_\_\_\_\_  
**Witness – Signature**