



*Partner Stamp or Label*

*Patient Stamp or Label*

**Center for Infertility and Reproductive Surgery**  
**GESTATIONAL CARRIER CONSENT - CARRIER**

***General:***

By signing below, I am/we are saying that I/we have:

- Read and understood the information in the In Vitro Fertilization and Gestational Carrier sections of the *Education Booklet for Informed Consent for Assisted Reproduction*, Version 02-2013.
- Read and understood the information in the booklet about the overall risks of assisted reproductive treatments.
- Had the procedures fully explained to me/us.
- Had all of my/our questions completely answered.

***Evaluation:***

By signing below, I/we are saying that I/we understand:

- That BWH CIRS cannot promise that the medical histories given by the intended parent(s) will be truthful. In addition, some medical conditions may not be known when the histories are given.
- That the intended parents are tested for certain diseases. This includes HIV which is the virus that causes AIDS. However, there is still a risk of this and other communicable diseases, and infections being given to me. Getting any of these diseases may mean that treatment including surgery is needed. In some cases, these diseases could lead to death.
- That putting an embryo into the uterus of an unrelated woman is a fairly new procedure. The psychological and emotional risks of this are not known at this time. This is especially true if the intended parents and the gestational carrier have a social relationship after the child is born.

***Care:***

By signing below, I am/we are saying that I/we agree:

- That I/we must not have unprotected sexual intercourse:
  - During the month ***before*** embryo transfer.
  - Until the results of the pregnancy tests are known ***after*** embryo transfer.
- That I will be taken care of by an obstetrician if I become pregnant from the embryo transfer.
- That the BWH CIRS has the right to decide to accept and treat me as a gestational carrier. The BWH CIRS also has the right to decide to stop this treatment at any time.



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***Costs:***

By signing below, I am/we are saying that I/we understand:

- That all costs for the gestational carrier cycle, including medicines, blood tests, medical and psychological evaluations, and surgical procedures, will be paid for by the intended parent(s).
- That there may be complications that cause additional medical and hospital expenses. The intended parent(s) must buy extra insurance to cover these expenses.

***Legal:***

I am/we are also saying that I/we have:

- Spoken with a lawyer before signing this Documentation of Informed Consent.
- Had a chance to get information and advice about the legal part of my/our decision to be a gestational carrier.
- That the BWH CIRS has not given me/us information about any law or legal matters having to do with my being a gestational carrier.
- I am not/We are not asking the BWH CIRS to give me/us legal advice in giving this consent.

***Claims:***

By signing below, I/we agree:

- To give up any rights and claims to any child(ren) that come(s) from these procedures. This is also true for my/our heirs, administrators, or executors.
- That after the pregnancy and delivery the child(ren) belong to the intended parents.

***Confidentiality:***

By signing below, I am/we are saying that I/we have been told:

- That information about me/us and my treatment will be kept confidential. This will be done as allowed as required by law.
- That information will be provided to the Centers for Disease Control and Prevention (CDC) for ongoing studies, and to assess treatment efficacies and demographic information.



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***My/Our Decision:***

By signing below, I am/we are saying that I/we have:

- Had the chance to talk about this decision with a physician and a social worker/psychologist.
- Asked the BWH CIRS to perform the procedures described in the In Vitro Fertilization and Gestational Carrier sections of the *Education Booklet for Informed Consent for Assisted Reproduction*, Version 02-2013.

\_\_\_\_\_  
Carrier's Signature      Date\_\_\_\_\_ Time\_\_\_\_\_ AM/PM

\_\_\_\_\_  
Carrier's Partner (if applicable) Signature      Date\_\_\_\_\_ Time\_\_\_\_\_ AM/PM

By my signature I am saying that I reviewed the above information with the patient, the patient verbalized understanding, and was provided opportunity to ask any questions.

\_\_\_\_\_  
Physician's Signature      

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 Date\_\_\_\_\_ Time\_\_\_\_\_ AM/PM