BRIGHAM AND WOMEN'S HOSPITAL

75 Francis Street, Boston, MA 02115

Patient Stamp or Label

Center for Infertility and Reproductive Surgery
INVITRO FERTILIZATION (IVF) CONSENT

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

- Read and understood the information in the In Vitro Fertilization sections in the *Education Booklet and Informed Consent for Assisted Reproduction*. This booklet is 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.

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

- That insurance may not cover all treatments. I/we understand that if I/we agree to undergo a treatment which is not covered by my/our insurance company that I/we will be responsible for paying for it before the treatment is started.

Body Fluids and Tissue: By signing below, I/we do or do not agree to the following:

Agree	*Do not Agree*	
☐	☐	That pictures may be taken of tissue or body fluids during surgery. Such tissue or body fluids may also be used and/or saved for diagnostic, scientific, or teaching purposes.
☐	☐	To donate my/our discarded embryos to the BWH IVF Lab for diagnostic, scientific, or teaching purposes. Such tissues are not destined for clinical use (either embryo transfer or cryopreservation) and would otherwise be disposed of in accordance with standard hospital policy.

If I/we do not agree to donate my/our body fluids and/or tissues, they will be disposed of in accordance with standard hospital policy.

Embryo or Egg freezing: I/We do ☐ do not ☐ plan on freezing.

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 and 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.

My/Our Decisions: By signing below, I am/we are saying that I/we:

- Have had the chance to talk about these decisions with a physician.
- Ask the BWH CIRS to perform the procedures described in the In Vitro Fertilization section of the *Education Booklet for Informed Consent for Assisted Reproduction*, Version 02-2013.

_____ Date_____ Time_____ AM/PM
Patient's Signature

_____ Date_____ Time_____ AM/PM
Partner's Signature

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.

_____ ☐☐☐☐☐ Date_____ Time_____ AM/PM
Physician's Signature

MEDICAL RECORDS COPY