CENTER FOR ADVANCED REPRODUCTIVE SERVICES
CONSENT TO THAWING AND UTILIZATION OF CRYOPRESERVED EMBRYOS

Female Name:_______________________________ Female ID#________________________________

Partner Name:_________________________________ Partner ID#_________________________________

Address:____________________________________

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We (I), the undersigned, request, authorize and consent to the thawing and utilization of cryopreserved (frozen) embryos stored by The Center for Advanced Reproductive Services, PC (The Center), and as appropriate, its employees, contractors, and consultants and authorized agents for us.

We (I) understand that there is no guarantee that any of the embryos will survive the thawing process. Furthermore, we (I) understand also that there is no guarantee that the transfer of thawed embryos will result in a conception. We (I) understand and consent that the number of embryos thawed is at the discretion of The Center staff in consultation with us (me). Furthermore, the number of embryos thawed will be determined by the embryo quality and number at freezing, the immediate post-thaw quality, the age of the female, the medical conditions leading to our (my) infertility and our (my) choice in consultation with our (my) physician.

Selective Assisted Hatching may be used in situations where the zona pellucida (the outer shell surrounding the embryo) is abnormally thick. This condition may compromise the ability of the embryo to implant in the uterine wall. Criteria for performing selective assisted hatching include appearance of the embryo and zona pellucida, age of the woman, advanced maternal age where a thickened zona is commonly seen, basal day 3 FSH levels and previous medical history. Literature suggests that the procedure may benefit older women, those with elevated day 3 FSH levels and some cases of unexplained infertility. This procedure (which must be performed immediately prior to embryo transfer) involves opening a small hole in the zona pellucida using micromanipulation techniques. There are risks associated with this technique. Embryos may be damaged during the process, reducing the number of embryos available for transfer. Despite the use of assisted hatching, implantation may not occur. We (I) acknowledge that we (I) have discussed the possibility of the need for the selective assisted hatching procedure with our physician and understand, agree and consent that (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):

- ❑ **Selective Assisted Hatching** may be utilized based on the best medical judgement of the Center staff at the time of the procedure. We (I) understand that we (I) will be notified if assisted hatching is performed.

  Female's Initials_____________________

  Partner's Initials _____________________

- ❑ **Selective Assisted Hatching** may ***not*** be used in conjunction with our (my) IVF cycle. We (I) understand that, as a result of this decision, pregnancy may not result.

  Female's Initials_____________________

  Partner's Initials _____________________

We (I) understand that, just as was the case with our (my) initial cycle of IVF using fresh embryos, the transfer of more than one embryo into the uterus may result in a multiple pregnancy (twins, triplets or more), with an increased risk of miscarriage, premature labor and premature birth. A premature delivery may jeopardize the life and long term health of a child and may result in substantial costs both financially and emotionally. Pregnancies with more than one baby in the uterus may also increase the occurrence of pregnancy related medical complications for the mother such as high blood pressure and diabetes. Multiple pregnancy also increases the likelihood that a cesarean section will be required. Parents raising children resulting from multiple births may be at increased risk for major mood disorders such as anxiety and depression.

We (I) understand that the process of utilizing the frozen/thawed embryos may require the use of hormones and monitoring using ultrasound and blood tests to determine the optimal time to perform the embryo transfer and to support the function of the uterine lining after transfer. The process also involves an embryo transfer as described in the IVF Consent that we have previously signed.

Thawing and Utilization of Cryopreserved Embryos has been explained to us (me), together with the known risks. We (I) understand the explanation that has been given to us. We (I) have had the opportunity to ask questions and those questions have been answered to our (my) satisfaction. Any further questions we (I) might have may be addressed to The Center staff or IVF/ET Program Director, Dr. John Nulsen at (860) 679-4580. We (I) acknowledge that Thawing and Utilization of Cryopreserved Embryos is being performed at our (my) request and with our (my) consent.

We (I) understand the confidentiality of medical records, including any photographs, X-rays or recordings, will be maintained in accordance with applicable state and federal laws. We (I) may request our records be released to other physicians. Data from your ART procedure will also be provided to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that CDC collect data on all assisted reproductive technology cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, CDC applied for and received an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that CDC has that identifies you will not be disclosed to anyone else without your consent.

We (I) acknowledge that this consent requires the signature of both members of the couple who signed the original embryo cryopreservation consent for embryo transfer. We (I) agree that if we (I) inherited these cryopreserved materials or obtained them from a known donor, copies of the agreements and/or consents to transfer or donate the materials must be provided along with this consent. In that case, only the signature of the individual(s) involved in that agreement is (are) required. We (I) understand, agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

NOTE: If TWO signatures are required, BOTH signatures must be notarized. If both partners cannot appear before the notary at the same time, then the form can be duplicated and each partner can sign separately.

_____/_____/_____ ____
Date Female Signature

_____/_____/_____ ____
Date Partner Signature*** **If no partner, write N/A**

Note: Notarization of BOTH signatures is required.

State of Connecticut)
)
County of ____________________)

On ____________________________, before me, ___________________________________(**Insert name of Notary**), personally appeared ____(**List only the names of individuals who actually appeared for this signature**), personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature __________________________________ (Seal)

THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES MUST RECEIVE THIS CONSENT FORM PRIOR TO THE TRANSFER OF THE MATERIALS. THIS FORM MAY BE MAILED TO:

John Nulsen, MD, Program Director
The Center for Advanced Reproductive Medicine
Dowling South Building
263 Farmington Avenue
Farmington, CT 06030
Tel: 860-679-4580

Physician Signature:

This consent has been discussed with the patient and her partner, if any.

_____/_____/_____ ____

Date Physician Signature