Mount Sinai Fertility
Sinai Health System

Mount Sinai Fertility
250 Dundas St W., Suite 700
Toronto, ON M5T 2Z8
tel: 416-586-4748; fax: 416-586-4686

IN VITRO FERTILIZATION CONSENT PACKAGE

Form # MSF -102 (Oct 2016)

This consent applies to all of the procedures for your upcoming in vitro fertilization (IVF) or in vitro fertilization and intracytoplasmic sperm injection (IVF/ICSI) treatment cycle. You must read the "In Vitro Fertilization (IVF) Information Package" and review the electronic MSF IVF Video prior to signing these consents.

Both partners (if applicable) must sign these consents, and they must be witnessed by a third party (someone different from the patient or partner). Please ensure you read the directions carefully, and complete each page of this package.

If you have any questions about the information provided, please speak to your doctor or nurse. A copy of this consent package will be provided to you.

IVF Cycle Treatment Plan:

Cycle Start Date (DD/MM/YYYY): _____

Eggs will be provided by:

☐ Patient: _____

☐ Known Donor: _____

☐ Donor ID: _____

Sperm will be provided by:

☐ Patient: _____

☐ Known Donor: _____

☐ Donor ID: _____

Embryo transfer to: ☐ Patient:_____ ☐ GC: _____ ☐ N/A

IVF TREATMENT

Each person (if applicable) must agree and initial under either "YES" or "NO" for each question. Please leave the Patient 2 box blank if you do not have a partner. Check the N/A box if a component of the treatment does not apply to your situation.

I/We, the undersigned, consent to the components of IVF as indicated below:	YES		NO		N/A
	Patient 1	Patient 2	Patient 1	Patient 2	
OVARIAN STIMULATION AND EGG RETRIEVAL					
FERTILIZATION AND EMBRYO DEVELOPMENT					
INTRACYTOPLASMIC SPERM INJECTION (ICSI) MSF recommends that you review the ICSI information in the IVF Information Package and consent to ICSI, even if ICSI is not planned. In some cases, ICSI may be unexpectedly required to improve your chances of pregnancy in the cycle.					
ASSISTED HATCHING					
EMBRYO TRANSFER					
EMBRYO FREEZING Annual storage fees will apply and must be paid prior to further treatment. If the annual storage fees are not paid, stored samples may be discarded by The Bank.					

RISKS OF IVF TREATMENT

I/We understand the risks of IVF including, but not limited to:

(Please initial beside each line, leave Patient 2 blank if not applicable)

Patient 1	Patient 2	
_____	_____	Risks of ovarian stimulation including ovarian hyperstimulation syndrome (OHSS)
_____	_____	Possibility of cycle cancellation due to poor or unusual response to medications
_____	_____	Risks of egg retrieval including sedation, bleeding, infection or organ puncture
_____	_____	Risks of multiple pregnancy (twins, triplets, etc.)
_____	_____	Possibility of pregnancy complications such as miscarriage or ectopic (tubal) pregnancy
_____	_____	Increased risks of early delivery or low birth weight
_____	_____	Increased risks of congenital abnormalities or birth defects
_____	_____	Unknown long term risks of fertility medications including ovarian cancer

EMBRYO FREEZING DISPOSITION

Frozen embryos will only be thawed for transfer with the consent of both partners (if applicable). Both partners (if applicable) must agree on the use and disposition of frozen embryos in the event of a change in circumstances such as a separation or divorce. If partners cannot agree on the disposition, the frozen embryos will remain in the custody of Mount Sinai Fertility at Mount Sinai Hospital until there is a legal settlement. Patients may choose to donate their embryos to the MSF Embryo Donation Program in the future. Embryo donors must complete specific screening and may not qualify for the program.

You may withdraw your consent at any time prior to embryo disposition by notifying or writing MSF staff.

FOR EACH LINE, BOTH PARTNERS (IF APPLICABLE) MUST AGREE TO AND INITIAL THE SAME BOX:

In the Event of:	Release embryos to patient 1 for their reproductive use	Release embryos to patient 2 for their reproductive use	Use embryos for training or in an approved research project	Discard frozen embryos*	Not applicable
Death of patient 1					
Death of patient 2					
Death of couple at the same time					

**For this option, a termination of storage form must be completed at the time of embryo disposition.*

RESEARCH INVESTIGATION AND TRAINING

During your IVF treatment, some of your eggs/sperm/embryos may not be suitable quality for use to achieve pregnancy. These materials may be used in research, to provide instruction in or to improve assisted reproductive procedures. All research studies must be approved by the Mount Sinai Hospital Research Ethics Board, and research involving embryos will be outlined in a separate research consent.

I/We agree to allow the use of the following for research, providing instruction in or improving assisted reproductive procedures:	**YES**		**NO**	
	Egg Provider	**Sperm Provider**	**Egg Provider**	**Sperm Provider**
Unused eggs				
Fluid from the follicles				
Cells from the follicles (not eggs)				
Unused sperm				
	Patient 1	**Patient 2**	**Patient 1**	**Patient 2**
Fragmented or abnormal-looking embryos				
Extra healthy embryos we choose not to freeze or donate				
My medical records to be reviewed for research purposes				

CONSENT

I/We consent to the IVF treatment, including components which I/We have agreed to above. I/We acknowledge that the nature, purpose and risks of the treatments and procedures have been fully explained by the clinical staff at the Mount Sinai Fertility. I/We, the undersigned, have read the "In Vitro Fertilization (IVF) Information Package." In addition, I/We have viewed the electronic IVF Video. I/We have had the opportunity to ask questions about this procedure and have had my/our questions answered to my/our satisfaction.

I/We hereby release and forever discharge Mount Sinai Hospital, its predecessors, successors, affiliates, agents, physicians and employees from any and all claims, liabilities and responsibilities which may arise in connection with the collection, handling, processing of eggs/sperm/embryos through our involvement in the IVF program (including all components I/We agree to above), any congenital, physical or mental abnormalities or defects in a child conceived, and all associated record keeping with our eggs/sperm/embryos, their disposal or destruction whether accidental or intentional, their release, and any and all use to which they may ultimately be put, however such liability may arise. The terms of this agreement will be binding on my/our heirs, successors, executors, administrators, guardians, attorneys, trustees, and me/us.

I/We understand I/We am/are free to withdraw consent to treatment or procedures at any stage. **I/We have read and understand this agreement, accept its terms and am/are signing it voluntarily.**

This consent is valid for one IVF cycle.

Date Signed (YYYY-MM-DD): _____ **Date Signed** (YYYY-MM-DD): _____

_____ _____

Patient 1 Signature Patient 2 Signature

_____ _____

Patient 1 Printed Name Patient 2 Printed Name

_____ _____

Witness Signature Witness Signature

_____ _____

Witness Printed Name Witness Printed Name