Mount Sinai Fertility
Sinai Health System

250 Dundas St W., Suite 700
Toronto, ON M5T 2Z5
tel: 416-586-4748; fax: 416-586-4686

PREIMPLANTATION GENETIC DIAGNOSIS AND/OR PREIMPLANTATION GENETIC SCREENING CONSENT

Form # MSF -106 (May 2016)

This consent applies to all of the procedures for your upcoming Preimplantation genetic diagnosis (PGD) and/or Preimplantation genetic screening (PGS) procedure. You must read the "Preimplantation Genetic Diagnosis (PGD) and/or Preimplantation Genetic Screening (PGS) Information Package" prior to signing these consents.

Both partners (if applicable) must sign this consent, 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.

"Patient" refers to the partner undergoing or who has previously undergone ovarian stimulation and egg retrieval, if applicable.

"Partner" refers to their partner, if applicable, who is participating in treatment.

If you have any questions about the information provided, please speak to your doctor or nurse. A copy of this consent will be provided to you. New consents must be signed for each PGD and/or PGS cycle.

To be completed by MSF: IVF Cycle Start: _____ /_____ /_____
DD MM YYYY

PREIMPLANTATION GENETIC DIAGNOSIS AND/OR PREIMPLANTATION GENETIC SCREENING PROCEDURE

BOTH PARTNERS (IF APPLICABLE) MUST AGREE AND INITIAL UNDER EITHER "YES" OR "NO" FOR EACH QUESTION. CHECK NOT APPLICABLE (N/A) IF A COMPONENT OF THE TREATMENT DOES NOT APPLY TO YOU.

I/We, the undersigned, consent to the components of PGD/PGS as indicated below:	YES		NO		N/A
	Patient	Partner	Patient	Partner	
PREIMPLANTATION GENETIC DIAGNOSIS (PGD) FOR SINGLE GENE DISORDER: _____					
PREIMPLANTATION GENETIC DIAGNOSIS (PGD) FOR CHROMOSOMAL REARRANGEMENTS					
PREIMPLANTATION GENETIC SCREENING (PGS), ALSO KNOWN AS COMPREHENSIVE CHROMOSOMAL SCREENING or CCS, FOR ANEUPLOIDY					

RISKS OF PGD AND/OR PGS PROCEDURE

I/We understand the risks of PGD and/or PGS including, but not limited to:
(PLEASE INITIAL BESIDE EACH LINE)

Patient	Partner	
_____	_____	Risk of not having embryos to biopsy
_____	_____	Risks of embryo biopsy
_____	_____	Risk of biopsy sample transport
_____	_____	Risks of PGD and/or PGS analysis including the possibility of misdiagnosis
_____	_____	Limitations of PGD and/or PGS including its accuracy, and the possibility of not getting a result or indeterminate results
_____	_____	Risk of not having embryos suitable to transfer
_____	_____	Prenatal screening is recommended after PGD and/or PGS to confirm the results
_____	_____	Embryos may be frozen while awaiting final results

CONSENT

I/We consent to PGD and/or PGS, including components which I 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 Mount Sinai Fertility. I/We, the undersigned, have read "Preimplantation Genetic Diagnosis (PGD) and/or Preimplantation Genetic Screening (PGS) Information Package". I/We have had the opportunity to ask questions about this procedure and have had my questions answered to my 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 PGD/PGS program (including all components I 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 us, our heirs, successors, executors, administrators, guardians, attorneys and trustees.

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

Signed this _____ (Day) day of _____ (Month) , _____ (Year)

_____ ✍ Patient Signature

_____ ✍ Witness Signature

_____ Patient Printed Name

_____ Witness Printed Name

Signed this _____ (Day) day of _____ (Month) , _____ (Year)

_____ ✍ Partner Signature

_____ ✍ Witness Signature

_____ Partner Printed Name

_____ Witness Printed Name