Mount Sinai Fertility
Sinai Health System

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

CONSENT FOR FROZEN EMBRYO THAW

Form # MSF -105 (August 2017)

I/We, the undersigned, hereby consent to the procedure of a **Frozen Embryo Thaw** and embryo transfer to:

☐ Patient: _____ ☐ Gestational carrier:_____ ☐N/A

Thawed embryos are transferred after uterine preparation. Assisted hatching may be performed prior to embryo transfer. In some cases, embryos may be grown in culture to a further stage of development. Embryos grown in culture may be re-frozen. If applicable, pre-implantation genetic diagnosis/screening (PGD/PGS) may be performed on the embryos in conjunction with either a fresh embryo transfer or re-freezing of embryos.

By signing this form, I/we agree that the recipient may present without their partner (if applicable) if an embryo transfer procedure is planned. This consent form will be valid for 60 days from the date of signing.

I/We acknowledge that the nature, purpose and contemplated effects of the treatments and procedures have been fully explained to my/our satisfaction by the clinical staff of Mount Sinai Fertility, Mount Sinai Hospital. Procedural details have also been explained to me/us, including how long it will take, and any expected risks and benefits.

I/We understand that:

a) While the purpose of these procedures is to establish a viable pregnancy, I/we understand that there is no guarantee of success. Not all frozen embryos survive the freezing and thawing process, resulting in embryos which are non-viable for transfer.
b) Every conceived pregnancy has a 3% chance of involving a major congenital abnormality, regardless of whether fertility therapy is used, although many such pregnancies fail to reach term delivery.
c) The outcome could be a multiple pregnancy, such as twins or triplets, or more.
d) I/We are free to withdraw consent for the treatments or procedures at any stage prior to embryo transfer.

For treatment cycles using a Gestational Carrier, I/We understand that at least one of the Intended Parents must be present at the time of the embryo transfer for identification purposes.

I/We have read and understand this agreement, accept its terms, and am/are signing it voluntarily.
This consent is valid for 60 days from the date of signing and for one frozen embryo transfer cycle.

Date Signed (YYYY-MM-DD): _____

_____ ✍
Patient 1 Signature

_____
Patient 1 Printed Name

_____ ✍
Witness Signature (cannot be Patient 2)

_____
Witness Printed Name (cannot be Patient 2)

Date Signed (YYYY-MM-DD): _____

_____ ✍
Patient 2 Signature

_____
Patient 2 Printed Name

_____ ✍
Witness Signature (cannot be Patient 1)

_____
Witness Printed Name (cannot be Patient 1)

Copy Distribution: W - Chart; Y - Patient(s); P - IVF Lab