Mount Sinai Fertility
Sinai Health System

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PREIMPLANTATION GENETIC DIAGNOSIS AND/OR PREIMPLANTATION GENETIC SCREENING CONSENT

Form # MSF -106 (August 2017)

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

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.

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.

PGD AND/OR PGS 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 1	Patient 2	Patient 1	Patient 2	
PGD FOR SINGLE GENE DISORDER: _____					
PGD FOR CHROMOSOMAL REARRANGEMENTS					
PGS, ALSO KNOWN AS COMPREHENSIVE CHROMOSOMAL SCREENING or CCS, FOR ANEUPLOIDY					

RISKS OF PGD AND/OR PGS PROCEDURE

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

Patient 1	Patient 2	
_____	_____	Possibility of not having embryos to biopsy
_____	_____	Risks associated with the biopsy of embryos
_____	_____	Risks associated with biopsy sample transport
_____	_____	Limitations of PGD/PGS including possibility of not obtaining a result or of obtaining indeterminate results
_____	_____	Limitations of PGD/PGS including its accuracy, possibility of misdiagnosis, as well as possibility of detecting mosaicism*
_____	_____	Possibility of not having embryos suitable to transfer
_____	_____	Limitations of PGD/PGS including strong recommendation to undergo prenatal diagnosis (ie. chorionic villus sampling (CVS) or amniocentesis) after PGD/PGS to confirm results
_____	_____	Possibility that embryos frozen while awaiting PGD/PGS results may not survive thawing
_____	_____	Possibility of having only mosaic embryos available for transfer, at which time genetic consultation is advised prior to transfer

EMBRYO FREEZING DISPOSITION

I/We, the undersigned, hereby authorize and direct Mount Sinai Fertility to (choose only ONE option by initialing in the box):	**Patient 1**	**Patient 2**
DISCARD my/our frozen embryos that have been determined to be aneuploid by genetic testing if and when they are the only remaining embryos in storage**		
USE my/our frozen embryos that have been determined to be aneuploid by genetic testing FOR RESEARCH, PROVIDING INSTRUCTION IN OR IMPROVING ASSISTED REPRODUCTIVE PROCEDURES if and when they are the only remaining embryos in storage**		
STORE my/our frozen embryos that have been determined to be aneuploid by genetic testing until I/We have instructed otherwise**		

**Mosaicism: a situation in which different cells in the same embryo have different numbers or arrangements of chromosomes*
***Aneuploid: the presence of an abnormal number of chromosomes in a cell, for example a human cell having 45 or 47 chromosomes instead of the usual 46*

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 the "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, 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 have read and understand this agreement, accept its terms, and are signing it voluntarily.

This consent is valid for one IVF-PGD/S 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 (cannot be Patient 2) Witness Signature (cannot be Patient 1)

_____ _____
Witness Printed Name (cannot be Patient 2) Witness Printed Name (cannot be Patient 1)