



IVF Treatment Plan

Patient name: _____ Date: _____ Time: _____

Partner name: _____ Date: _____ Time: _____

Provider of Sperm

We (I) plan to use sperm from:

- Patient
- Partner
- Donor (specify arrangement): _____

Initials: _____ / _____

Provider of Eggs

We (I) plan to use eggs from:

- Patient
- Partner
- Donor (specify arrangement): _____

Initials: _____ / _____

Carrier of embryos

We (I) plan to transfer the embryos into:

- Patient
- Partner
- A Gestational Carrier
----if known, her name: _____

Initials: _____ / _____

Limit on Number Inseminated/Plan for Eggs Not Inseminated

Regarding the number of eggs to expose to sperm, we (I) choose:

- Inseminate ALL Mature Eggs
- Inseminate SOME Mature Eggs: number or fraction of eggs to be exposed to sperm:

Regarding the eggs **NOT** exposed to sperm for fertilization, we (I) choose:

- Freeze for my later use
- Donate to:
 - Research
 - Another person or couple
- Discard

Initials: _____ / _____

INFORMED CONSENT FOR IN VITRO FERTILIZATION (IVF)

A. **IVF General.** By my/our signature(s) below, I/we confirm that:

1. I/we have read and understood the information presented in this In Vitro Fertilization Consent Booklet and the nature and purpose of the procedures have been explained to me/us. The risks and benefits of the procedures have been explained to me/us. In addition, the alternative treatments and the risks and benefits of these alternatives have been explained to me/us. I/we have had the opportunity to ask questions and have received all the information I/we desire about the procedures.

2. I/we understand that in an emergency, there may be different or further procedures required if the doctor believes they are necessary, and I/we consent to such procedures.

3. I/we understand that the administration of anesthesia and/or sedation and associated procedures may be necessary to assure safety and comfort during the procedure, and I/we consent to such procedures if indicated. I/we understand certain risks and complications may be associated with the use of anesthesia and/or sedation and that the appropriate practitioner will discuss these risks with me prior to the procedure.

4. I/we consent to the taking of ultrasound images and pictures, videotapes, or other electronic reproductions of the eggs/sperm/embryos and the use of the pictures, videotapes, or electronic reproductions for treatment or internal or external activities consistent with Stanford's mission of education and research, conducted in accordance with Stanford policies.

B. **Intracytoplasmic Sperm Injection (ICSI).** I/we have discussed the possibility of the need for ICSI with my/our physician and understand, agree and consent that:

- ICSI will NOT be used.
- ICSI will be used on SOME mature eggs.
- ICSI will be used on ALL mature eggs.
- ICSI will NOT be used, UNLESS the semen at time of egg retrieval is sub-optimal based on the best medical judgment of Stanford staff. In these cases ICSI may be used. I/we understand that I/we will be notified if ICSI is performed.

Patient
Initials

Partner
Initials

C. **Assisted Hatching.** I/we have discussed the option of assisted hatching with my/our physician and understand, agree and consent that:

- Assisted hatching will NOT be performed.
- Assisted hatching of embryo(s) selected for transfer will be performed.
- Assisted hatching of embryo(s) selected for transfer will NOT be performed unless, at the time of transfer, assisted hatching is determined to be necessary in the best medical judgment of Stanford staff.
- Assisted hatching will performed as part of embryo biopsy procedure for pre-implantation in genetic testing.

Patient	Partner
Initials	Initials

D. **Preimplantation Genetic Diagnosis and Screening (PGD/PGS).** I/we have discussed the use of preimplantation genetic testing with my/our physician and understand, agree and consent to:

- Chromosomal Screening will NOT be performed.
- Chromosomal Screening of all blastocysts, regardless of number
- Chromosomal Screening of all blastocysts if >_____ are available for testing (in consultation with embryology lab staff)
- Single Gene Testing will NOT be performed.
- Single Gene Testing for _____

Patient	Partner
Initials	Initials

E. **Excess Embryos:** I/we make the following decision with respect to excess embryos remaining following my/our treatment:

- I/we consent to have the excess embryos frozen. (*Must complete Informed Consent to Embryo Freezing and Frozen Embryo Disposition*)

Patient	Partner
Initials	Initials

- I/we do not wish to freeze excess embryos. I/we desire the following disposition of any excess embryos:

- Donate to research.** Donated embryos and oocytes may be used by researchers interested in the study of human reproduction or development or human embryonic stem cell research. By initialing this choice, you may be contacted by a Stanford University research coordinator who will provide additional information and/or a separate research consent form.

Patient	Partner
Initials	Initials

AND/OR

Donate to quality improvement techniques. Donated embryos and oocytes may be used in ongoing efforts to develop and improve IVF techniques, train staff and conduct quality control.

Patient
Initials

Partner
Initials

Donate to another person or couple.

Patient
Initials

Partner
Initials

OR

Discard. The excess embryos or oocytes will be discarded in accordance with current institutional and department policies. The excess embryos or oocytes will no longer be available for attempting pregnancy.

Patient
Initials

Partner
Initials

F. **Clinically Unsuitable or Non-Selected Materials:** I/we agree to the following disposition of my/our oocytes and embryos that are unsuitable for clinical use or otherwise not selected or cryopreserved:

Donate to research: Oocytes and embryos that are unsuitable for clinical use or otherwise not selected or cryopreserved may be donated to research. Donated materials may be used by researchers interested in the study of human reproduction or development or human embryonic stem cell research. By initialing this choice, you may be contacted by our research coordinator who will provide additional information and a separate research consent form.

AND

Donate to quality improvement techniques: Donated materials may be used in ongoing efforts to develop and improve IVF techniques, train staff and conduct quality control.

OR

Discard: Oocytes and embryos that are unsuitable for clinical use or otherwise not selected or cryopreserved will be discarded in accordance with current institutional and department policies.

G. I/we understand this Informed Consent for In Vitro Fertilization, including the procedures and disposition instructions set forth above, will remain in effect until one of the following events occurs: (i) one (1) calendar year has passed from the date of signature, (ii) death of patient or patient's partner, (iii) dissolution of the patient's marriage or partnership, (iv) patient's successful pregnancy which results in a live birth, or (v) written notice to Stanford of withdrawal of consent by the patient and/or the patient's partner, if applicable. I/we acknowledge and agree that in the event of the dissolution of the patient's marriage or partnership or a live birth, Stanford will require the patient and

the patient's partner to execute a new consent form prior to the performance of any additional procedures.

H. I/we understand that this original consent form will be maintained in my medical record and a copy will be provided to me/us. I/we understand that this consent is an important document and should be retained with other vital records.

X

Patient Signature

Date

Time

Patient Name

Date of Birth

X

Partner Signature

Date

Time

Partner Name

Date of Birth

Informed Consent Attestation:

I have discussed the IVF procedures and the disposition instructions, including the risks, benefits, and alternatives with the patient and their partner. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment. All questions were answered and the patient (and their partner, if applicable) consents to the IVF procedures.

X

Physician Signature

Date

Physician Name

Time

X

Translator Signature

Language

Date of Translation

Time