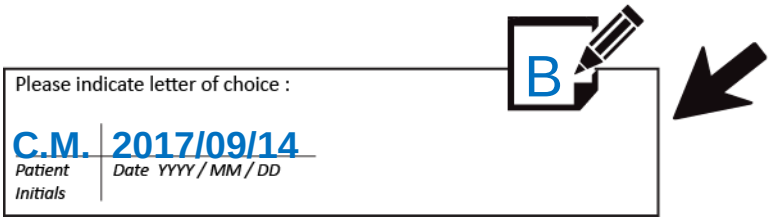
MUHC Reproductive Centre
Egg Freezing for Fertility Preservation Treatment Consent

Instructions on completing the Egg Freezing for Fertility Preservation Treatment Consent

Each section must be initialed as indicated.

On some pages, you will be required to fill in your choice then initial. Please ensure that your selection is clearly marked in the indicated box along with your initials.

Example:



Consent Signature (page 4):

You should clearly print your name, fill requested information, and sign where indicated in the presence of a witness.

The witness may be anyone who knows you well (neighbor, friend, relative, etc.). The role of the witness to the signatures is simply to confirm the identity of the patient and partner signing the consent form. The witness should clearly print his/her name and then sign the form.

Please make a copy of the signed consent form to keep for your records.

Please note that our nursing staff cannot issue a treatment calendar if this consent is incomplete or missing from your chart.

Should you have any questions or concerns regarding this consent form, please call 514-843-1650 for a review of consent appointment with a medical staff member.

MUHC Reproductive Centre
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Patient

RAMQ
First Name
Last Name
Date of Birth (YYYY/MM/DD)
Hospital Card Number

Please check the treatment that was ordered by your physician.

☐ Ovarian Stimulation and Egg Collection

I consent to undergo ovarian stimulation and egg collection for fertility preservation purposes. I have been informed that:

- I will take various medications to prepare the eggs in my ovaries to be collected. There are possible risks and side effects associated with these medications;
- Treatment may be cancelled at any stage between ovarian stimulation and egg collection. I will be informed of the reason(s) for cancellation;
- Medication and sedation will be given as necessary during the egg collection procedure;
- The egg collection procedure has possible complications such as bleeding and infection;
- Eggs may not be found or may not mature properly. Only mature eggs can be frozen;
- Immature eggs will be disposed of in accordance with standard protocol;
- The mature eggs collected will be frozen for my own reproductive purposes.

Please initial (if applicable) :

Patient Initials	*Date YYYY / MM / DD*

☐ Egg Collection Without Ovarian Stimulation

I consent to undergo egg collection for fertility preservation purposes. I have been informed that:

- I may take medications to help the eggs mature;
- Treatment may be cancelled at any time before the egg collection. I will be informed of the reason(s) for cancellation;
- Medication and sedation will be given as necessary during the egg collection procedure;
- The egg collection procedure has possible complications such as bleeding and infection;
- Eggs may not be found or may not mature properly. Only mature eggs can be frozen;
- Eggs will be treated in the lab to monitor and assist the maturation process;
- Immature eggs will be disposed of in accordance with standard protocol;
- The mature eggs collected will be frozen for my own reproductive purposes.

Please initial (if applicable) :

Patient Initials	Date YYYY / MM / DD

Frozen Eggs — In the Event of Death

In the event of my death, if there are remaining frozen eggs in storage, I consent to:

a. Donate them to a specific individual for his/her future reproductive use:

Name	Date of Birth	Medicare
Telephone Number	Email	

I, the designated recipient, am aware of and consent to receiving any remaining frozen eggs.

Designated recipient signature	Date YYYY/ MM / DD

b. Donate them for teaching purposes, after which they will be disposed of in accordance with standard protocol.

c. Dispose of them in accordance with standard protocol.

Please indicate letter of choice :

Patient Initials	Date YYYY / MM / DD

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I understand and have been informed of:

Treatment

- Treatment will be performed by the medical team of the MUHC Reproductive Centre (the Clinic);
- Indications for, possible risks, and alternative treatment options;
- Blood tests for transmissible diseases are required before the start treatment. If test results are abnormal, or not available, or not up to date, treatment may be delayed or cancelled.
- The availability of psychological support;
- Although a few studies suggest fertility treatments may be associated with negative long-term effects, most studies do not support these findings;
- The staff of the Clinic may review my medical chart for selecting potential participants in a research study approved by the MUHC review board and the central ethics board of the Ministry;
- I may be contacted in the future for long-term follow-up.

Frozen Eggs

- All reasonable care will be taken, but neither the staff nor the Clinic can accept liability for damage of frozen egg(s);
- There is no guarantee that any eggs will survive the freezing and/or thawing process;
- Intra-Cytoplasmic Sperm Injection (ICSI) involves the injection of a single sperm directly into a mature egg. This technique, which carries a low risk of damaging the egg, will be used in the future to inseminate my eggs;
- There is no guarantee of achieving pregnancy using stored eggs. The chance of a pregnancy may be reduced when frozen/thawed eggs are used;
- Before using my frozen eggs, I will be informed of the likelihood of pregnancy, the risks of pregnancy and possible complications;
- The MUHC Reproductive Centre can release my frozen eggs to another centre for assisted procreation. For this type of transfer, I must make the request in writing one month prior to the date of transfer; I am responsible for all transportation costs.
- I must remain in contact with the Clinic on an annual basis to reconfirm my intent regarding the storage and disposition of my frozen eggs. It is my responsibility to inform the Clinic of a change of address or contact information. If I fail to make contact with the Clinic for more than 5 years, the Clinic has the right to dispose of frozen eggs according to Ministry guidelines;
- After the first year, storage fees will apply. Retroactive charges will be incurred if I fail to remain in contact with the Clinic;
- Currently, fertility preservation for men and women diagnosed with cancer is covered by the Quebec Health Insurance Plan (RAMQ) as per Bill 20 (chapter 25-34.3). The plan covers the cost of storing eggs or embryos for the first five years.

Withdrawal of Consent

- I may withdraw my consent regarding any of my above choices at any time before the choice is executed, by notifying the Clinic in writing.
- The withdrawal of consent will be acknowledged in writing by a member of the professional staff of the Clinic.

Signature of Consent

I understand that the laws of Canada and of the Province of Quebec shall govern the relationship between myself and the Clinic and any health professional involved in my care.

PATIENT CONSENT

I have been given time to consider the content of this document and the opportunity to make further inquiries before signing this form. I consent to the described treatment.

Patient Name (Print)	*Signature*	*Place (City)*	*Date (YYYY/MM/DD)*
Witness Name (Print)	*Signature*	*Place (City)*	*Date (YYYY/MM/DD)*