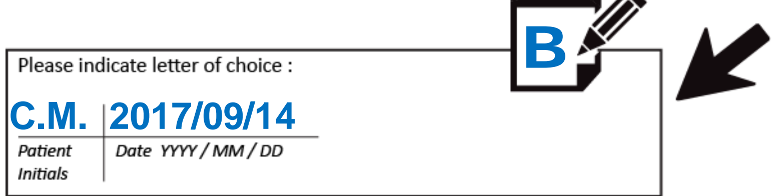
Instructions on completing the Egg Donor Treatment Consent Form

All sections must be initialed as indicated.

On some pages, you will be required to fill in selections then initial in several places. Please ensure that your selections are clearly marked in the indicated boxes along with your initials.

Example:



Consent Signature Page (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 consent appointment with a medical staff member.

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MUHC Reproductive Centre
Consent to Donate Eggs

Egg Donor

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 request and consent to undergo a treatment cycle involving ovarian stimulation and egg collection for the purpose of donating my eggs for the reproductive purposes of a Recipient or Intended Parent (s). I have been informed that:

- I will take various medications to prepare the eggs in my ovaries. There are possible risks and side effects associated with these medications;
- If no appropriate contraceptive method is used, I will be exposed to a high risk of pregnancy during the treatment cycle;
- 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 used for fertilization;
- There is no guarantee of fertilization of any egg(s). Unfertilized eggs will be disposed of in accordance with standard protocol.

Please initial (if applicable) :

Patient Initials	*Date YYYY / MM / DD*

OR

☐ **Egg Collection Without Ovarian Stimulation**

I request and consent to undergo a treatment cycle involving egg collection for the purpose of donating my eggs for the reproductive purposes of a Recipient or Intended Parent (s). I have been informed that:

- I may take medications to help the eggs mature;
- Treatment may be cancelled at any stage between start of treatment 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 will be used for fertilization;
- Eggs will be treated in the lab to monitor and assist the maturation process;
- There is no guarantee of fertilization of any egg(s). Unfertilized eggs will be disposed of in accordance with standard protocol.

Please initial (if applicable) :

Patient Initials	*Date YYYY / MM / DD*

Donor Egg Recipient or Intended Parent(s)

I consent to donate all my retrieved eggs to:

a. a designated Recipient or Intended Parent(s)

Name of Recipient	*Date of Birth*

OR

Intended Parent #1	*Date of Birth*
Intended Parent #2 (if applicable)	*Date of Birth*

b. an anonymous Recipient or Intended Parent(s), chosen by ______________________________

c. my partner for the purpose of our common parental project

By selecting option A or B, I am relinquishing all legal rights and obligations to the offspring that may result from the donated eggs.

Please indicate letter of choice :

Patient Initials	*Date YYYY / MM / DD*

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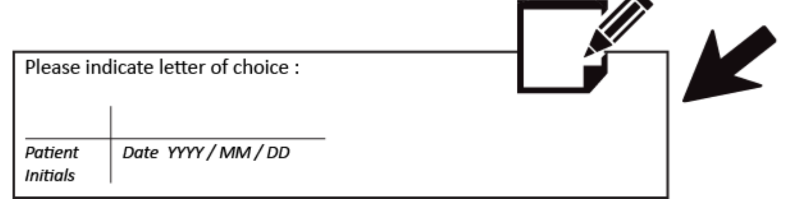
Disposition of Unused Poor Quality Embryos

If after embryo transfer there are unused embryos that are not suitable for freezing, in accordance with the Recipient's wishes, I consent to:

a. Donate them for an approved research project (which would be discussed with me/us) or for teaching purposes, after which they will be disposed of in accordance with standard protocol.
b. Dispose of them in accordance with standard protocol.

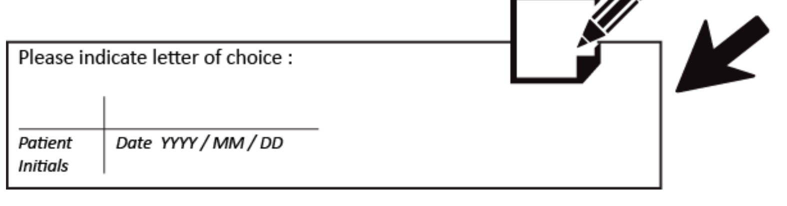


Frozen Embryos

Donor's Choice

If there are remaining unused embryos in storage when the Recipient/Intended Parent(s) has/have finished treatment(s), or if the couple's union breaks down (if applicable), or in the event of death of both partners, in accordance with the Recipient's wishes, I consent to:

a. Donate them for an approved research project (which would be discussed with me/us) or for teaching purposes, after which they will be disposed of in accordance with standard protocol.
b. Dispose of them in accordance with standard protocol.



I understand and have been informed of:

Counselling and Legal Aspects

- The requirement of psychological consultation;
- The MUHC Reproductive Centre (the Clinic) cannot provide legal advice regarding egg donation;
- I have made this decision to do treatment of my free will without any coercion or undue influence;
- I agree to complete the donor information form before the start of treatment;
- The Clinic will not inform me of any pregnancy resulting from the use of my donated eggs.

Treatment

- Blood tests for transmissible diseases are required before the start of my treatment. If test results are abnormal, or not available, or not up to date, treatment may be delayed or cancelled;
- Treatment will be performed by the medical team of the MUHC Reproductive Centre;
- Indications for, possible risks, and alternative treatment options;
- It is my responsibility to inform the Clinic of any newly diagnosed illness or infection or any exposure to such a situation;
- Although a few studies suggest fertility treatments may be associated with negative long-term effects, other 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;
- It is my responsibility to inform the Clinic of a change of address. I may be contacted in the future for long-term follow-up;

Withdrawal of Consent

- I may withdraw my consent regarding any of my above choices by notifying the Clinic in writing; however, I cannot withdraw my consent if my donation has already been used (i.e. once my eggs have been collected and/or fertilized).
- The withdrawal of the 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)*