


**Surrogacy Frozen Embryo Replacement Cycle (FERC)  
Consent of Gestational Carrier (Surrogate) and Commissioning Couple (Intended Parent(s))**

**Instructions on completing the treatment consent form**

Each section must be initialed by both the intended parent(s) and the gestational carrier as appropriate. Please ensure that your initials are clearly marked.

Example:

Please initial (if applicable) :			
<b>C.M.</b>	<b>2017/09/14</b>	<b>S.T.</b>	<b>2017/09/14</b>
<small>Intended Parent #1 Initials</small>	<small>Date YYYY / MM / DD</small>	<small>Intended Parent #2 Initials</small>	<small>Date YYYY/ MM / DD</small>



**Consent Signature (page 6):**

You should clearly print your names, 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 treatment 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.



**Surrogacy Frozen Embryo Replacement Cycle (FERC)  
Consent of Gestational Carrier and Commissioning Couple (Intended Parent(s))**

***Intended Parent #1***

***Intended Parent #2***

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

***Gestational Carrier (Surrogate) undergoing treatment***

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

Please check the treatment that was prescribed by your physician.

**Frozen Embryo Replacement Cycle (FERC)**


**Gestational Carrier (Surrogate)**

I consent to treatment involving a frozen embryo replacement cycle (FERC) with embryos created by the Commissioning Couple (Intended Parent(s)) for whom I have agreed to act as Gestational Carrier (Surrogate). I have been informed that:

- I may have to take various medications to prepare my uterus to receive the embryo(s). There may be risks and side effects associated with these medications;
- My cycle may be cancelled at any point leading up to (and including) embryo transfer.
- There is no guarantee that a pregnancy will be achieved following this treatment.

Please initial (if applicable) :

<i>Gestational Carrier (Surrogate) Initials</i>	<i>Date YYYY / MM / DD</i>



**Frozen Embryo Replacement Cycle (FERC)**


**Commissioning Couple (Intended Parent(s))**

I/we consent to proceed with a Frozen Embryo Replacement Cycle (FERC) with transfer to a Gestational Carrier in order to attempt pregnancy. I/we have been informed that:

- No assurance can be given that any of the frozen embryos will survive thawing or be suitable for transfer;
- The embryo shell will be thinned using assisted hatching to improve implantation;
- There is no guarantee that a pregnancy will be achieved following this treatment.

Please initial (if applicable) :

<i>Intended Parent #1 Initials</i>	<i>Date YYYY / MM / DD</i>	<i>Intended Parent #2 Initials</i>	<i>Date YYYY / MM / DD</i>



We (intended parent(s) and gestational carrier) understand and have been informed of:

### **Counselling and Legal Aspects**

- The requirement for psychological consultation;
- The MUHC Reproductive Centre (the Clinic) cannot provide legal advice regarding surrogacy arrangements and filiation of children born to them;
- We must consult a lawyer regarding legal aspects of surrogacy arrangements and filiation of children born of them before treatment can commence;
- We must provide a letter from our lawyer confirming the surrogacy agreement.

### **Treatment**

- Treatment will be performed by the medical team of the MUHC Reproductive Centre;
- Indications for, possible risks, and alternative treatment options;
- Blood tests for transmissible diseases are required for the gestational carrier and her partner (if applicable) before the start of the treatment. If test results are abnormal, not available, or not up to date, treatment may be delayed or cancelled;
- Although a few studies suggest fertility treatments may be associated with negative long-term effects, other studies do not support these findings;
- All reasonable care will be taken, but neither the staff nor the Clinic can accept liability for damage of frozen embryos;
- The staff of the Clinic may review our medical charts for selecting potential participants in a research study approved by the MUHC Ethics Review Board;
- We will provide the Clinic information about the outcome (result) of treatment and the outcome of any pregnancy resulting from treatment. We may be contacted in the future for long-term follow-up.

### **Frozen Embryos**

- The MUHC Reproductive Centre can release frozen eggs, sperm and embryos only to another centre for assisted procreation. For this type of transfer, the Intended Parent(s) must make the request in writing (one month) prior to the date of transfer;
- I/We, the intended parent(s), must remain in contact with the Clinic on an annual basis to reconfirm my/our intent regarding the storage and disposition of my/our frozen embryos. It is my/our responsibility to inform the Clinic of a separation/divorce, change of address or contact information. If I/we fail to make contact with the Clinic for more than 5 years, the Clinic has the right to dispose of frozen embryos according to Ministry guidelines;
- After the first year, storage fees will apply. Retroactive charges will be incurred if I/we, the intended parent(s), fail to remain in contact with the Clinic.

## **Pregnancy Risks**

- The Clinic is required to follow Quebec law in determining the number of embryos that can be transferred at each transfer. In most treatments, a single embryo will be transferred;
- A multiple pregnancy (more than one baby) is more likely when more than one embryo is transferred. The risk of complications during and after pregnancy and at delivery is greater with a multiple pregnancy;
- As in a natural pregnancy, there is a risk of the baby having an abnormality;
- Complications of pregnancy may be greater with infertility and/or treatments of infertility;
- Prenatal testing can identify some fetal genetic abnormalities and should be considered by all patients;
- As in natural conception, there is a risk of ectopic pregnancy (pregnancy outside the uterus), and of miscarriage.

## **Withdrawal of Consent**

- I/we, the intended parent(s), can withdraw consent to use my/our frozen embryos. This withdrawal must be given in writing to the Clinic before use of the embryo(s).
- I, the gestational carrier, may withdraw my consent at any time before the embryo transfer 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.

## What You Need To Know About CMV and Egg Donation

### What (CMV)?

It is a common virus from the herpes viruses' family. It is harmless to most people, and most people have caught the virus by the time they reach adulthood.

### What are the symptoms of CMV Infection?

On occasion, CMV infection will cause temporary symptoms such as fever, sore throat, fatigue and swollen glands.

### How is CMV transmitted?

CMV is transmitted by close contact with body secretions such as urine, saliva, feces, blood, semen and cervical secretions.

### Who is at risk from a contact with a person with active CMV?

Two groups of people are particularly at risk. Immunosuppressed patients will be at risk because they can develop an acute illness. The unborn children of women who catch CMV (for the first time) during pregnancy are also at risk because CMV may cross the placenta and causing "Congenital" infection.

### What are the risks of congenital CMV?

Congenital CMV may affect the central nervous system causing varying degrees of mental retardation or hearing loss. It may also lead to pneumonia, liver and spleen infection or smaller-than-normal head size (Cytomegalic inclusion disease).

### What are the implications of donation between a CMV (+) Donor and CMV (-) recipient?

In normal circumstances, fewer than half of the women who catch CMV during pregnancy will pass it to their babies and only some infected babies will develop symptomatic infections, either at birth or during the first few years of life. It is not known whether CMV transmission can occur through egg donation from a donor who carries the virus. If CMV transmission can occur, it is not known what the risk is that the mother will contract the infection or what the outcome would be for the fetus. For this reason, egg donation from a donor who carries CMV to a recipient who has not been infected with CMV is not generally recommended. One study has shown that CMV is not present on eggs from CMV positive donors<sup>1</sup> however no other studies have been done that repeat this finding and at present it must be concluded that the risk of transmission via egg donation is more likely theoretical but may be possible.

*1. Is there a risk of cytomegalovirus transmission during in vitro fertilization with donated oocytes? Witz CA, Duan Y, Burns WN, Atherton SS, Schenken RS. Fertil Steril. 1999 Feb; 71(2): 302-7.*

## Signature of Consent

We, the intended parent(s) and gestational carrier, understand that the laws of Canada and of the Province of Quebec shall govern the relationship between ourselves and the Clinic and any health professional involved in my/our care.

### PATIENT CONSENT — GESTATIONAL CARRIER (SURROGATE)

I have been given time to consider the information in this document and the opportunity to ask questions before signing. I consent to the treatment described in this form.

\_\_\_\_\_  
*Patient Name (Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*

\_\_\_\_\_  
*Witness Name (Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*

### INTENDED PARENT #1

I have been given time to consider the content of this document and the opportunity to ask questions before signing.

\_\_\_\_\_  
*Intended Parent #1 Name  
(Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*

\_\_\_\_\_  
*Witness Name (Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*

### INTENDED PARENT #2

I have been given time to consider the content of this document and the opportunity to ask questions before signing.

\_\_\_\_\_  
*Intended Parent #2 (Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*

\_\_\_\_\_  
*Witness Name (Print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Place (City)*

\_\_\_\_\_  
*Date (YYYY/MM/DD)*