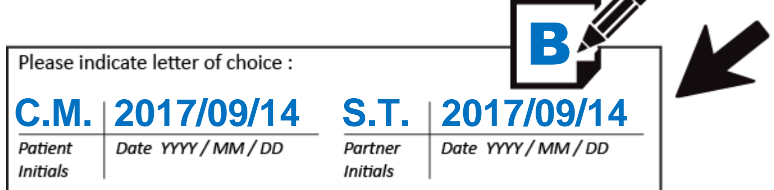
Instructions on completing the treatment consent form

All sections must be initialed by both partners 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 6):

You and your partner (if applicable) 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.

MUHC Reproductive Centre

Embryo Freezing for Fertility Preservation Treatment Consent

Patient undergoing treatment	*Spouse/Partner (if applicable)*
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

Please check the treatment that was ordered by your physician.

☐ **IVF (*in vitro* fertilization)**

I consent to undergo IVF treatment for fertility preservation purposes. I and my partner (if applicable) 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;
- Treatment may be cancelled at any stage between ovarian stimulation and egg collection. I/We will be informed of the reasons for cancellation;
- Medication and sedation will be given as necessary during the egg collection;
- 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 achieving fertilization of any egg(s). Unfertilized eggs will be disposed of in accordance with standard protocol;
- If necessary, the ICSI technique may be used to inseminate my egg(s). Intra-Cytoplasmic Sperm Injection (ICSI) is a technique that involves the injection of a single sperm directly into a mature egg, which carries a low risk of damaging the egg;
- There is no guarantee embryos will develop normally;
- The good quality embryos will be frozen (cryopreserved) for my/our own reproductive purposes.

Please initial (if applicable) :

Patient Initials	*Date YYYY / MM / DD*	*Partner Initials*	*Date YYYY / MM / DD*

OR

☐ **IVM (*in vitro* maturation)**

I consent to undergo IVM treatment for fertility preservation purposes. My partner (if applicable) and 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/We will be informed of the reasons 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 achieving fertilization of any egg(s). Unfertilized eggs will be disposed of in accordance with standard protocol;
- Intra-Cytoplasmic Sperm Injection (ICSI), which is routinely used in IVM cycles, involves the injection of a single sperm directly into a mature egg. This technique carries a low risk of damaging the egg;
- There is no guarantee embryos will develop normally;
- The embryos created will be frozen (cryopreserved) for my own/our reproductive purposes.

Please initial (if applicable) :

Patient Initials	Date YYYY / MM / DD	Partner Initials	Date YYYY / MM / DD

Sperm that will be used to fertilize eggs will be:

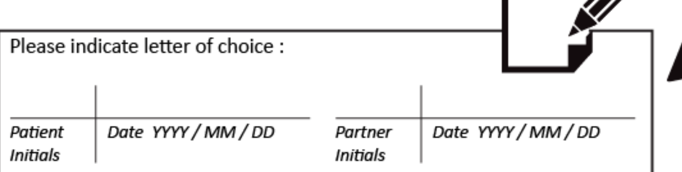
a. My partner's sperm.

b. My partner's sperm, or if necessary, donor sperm from a sperm bank recognized by Health Canada.

c. Donor sperm only, from a sperm bank recognized by Health Canada.

d. Directed donation. Provide name and date of birth of donor:

Donor's Full Name ____________________ *Date of birth (YYYY / MM /DD)* ____________________

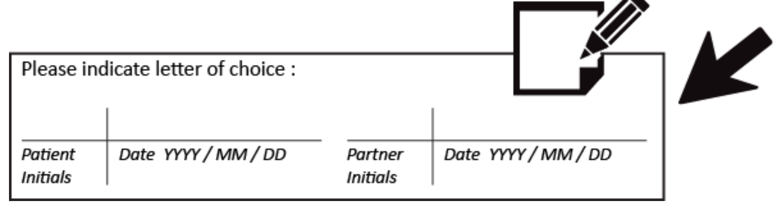


Disposition of Poor Quality Embryos

If there are poor quality embryos that are not suitable for freezing, I/we 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 — In the Event of Death

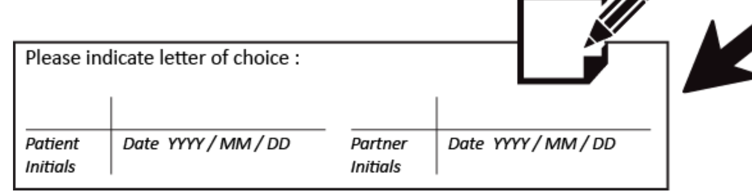
Patient's Choice

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

a. Donate them to my surviving partner for his/her future reproductive purposes.

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

c. Dispose of them in accordance with standard protocol.



Frozen Embryos — In the Event of Death

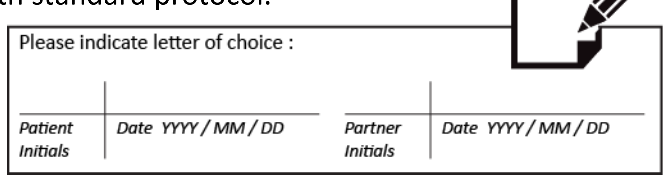
Partner's Choice (if applicable)

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

a. Donate them to my surviving partner for his/her future reproductive purposes.

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

c. Dispose of them in accordance with standard protocol.



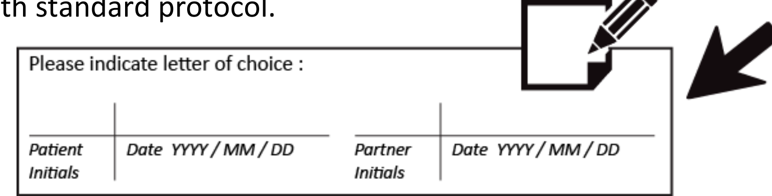
Frozen Embryos — In the Event of Death of Couple at the Same Time

Couple's Choice (if applicable)

In the event of our simultaneous death, if there are remaining frozen embryos in storage, we consent to:

a. Donate them 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/we 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 for me and my partner (if applicable), before the start of my/our 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;
- A consultation with our psychologist if using sperm donation (sperm bank or directed donation).
- 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/our 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/we may be contacted in the future for long-term follow-up.

Frozen Embryos

- All reasonable care will be taken, but neither the staff nor the Clinic can accept liability for damage of frozen embryo(s);
- There is no guarantee that any embryos will survive the freezing and/or thawing process;
- There is no guarantee of achieving pregnancy using stored embryos. The chance of a pregnancy may be reduced when frozen/thawed embryos are used;
- Before using my frozen embryos, I will be informed of the likelihood of pregnancy, the risks of pregnancy and possible complications;
- The MUHC Reproductive Centre can release frozen eggs, sperm and embryos only to another centre for assisted procreation. For this type of transfer, both partners must make the request in writing one month prior to the date of transfer; We are responsible for transportation fees;
- I/we 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 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 or my partner may withdraw my/our consent regarding any of my/our above choices at any time before the choice is executed, by notifying the Clinic in writing;
- I or my partner can withdraw consent to use my/our embryos. This withdrawal must be given in writing to the Clinic before use of the embryo(s).
- The withdrawal of consent will be acknowledged in writing by a member of the professional staff of the Clinic.
- If sperm is from a directed donation, I understand that the donor can withdraw his consent in writing until the time the sperm is prepared for use.

Signature of Consent

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

PATIENT CONSENT

I, the intended parent, 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)*

PARTNER CONSENT (If applicable)

I, the intended parent, acknowledge that we will be treated together. I have been given time to consider the content of this document and the opportunity to make further inquiries before signing.

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