


**MUHC Reproductive Centre
Consent of Commissioning Couple (Intended parent(s)) to IVF or IVM Treatment
and Embryo Transfer to a Gestational Carrier (Surrogate)**

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:



| | | | |
|------------------------------------|----------------------------|-----------------------------|----------------------------|
| Please indicate letter of choice : | | | |
| C.M. | 2017/09/14 | S.T. | 2017/09/14 |
| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |

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.

Consent of Commissioning Couple (Intended parent(s)) to IVF or IVM Treatment and Embryo Transfer to a Gestational Carrier (Surrogate)

| <i>Patient</i> | <i>Partner</i> |
|----------------------------|----------------------------|
| 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 |

Consent of Commissioning Couple (Intended Parent(s)) to IVF or IVM Treatment and Embryo Transfer to a Gestational Carrier (Surrogate)

As discussed and ordered by my/our physician:

Please check the treatment that was ordered by your physician.

IVF (in vitro fertilization)

I consent to undergo IVF treatment in order to create embryos that will be transferred to a Gestational Carrier (Surrogate). 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 embryo transfer;
- 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 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 embryos created will be reserved for my/our own reproductive purposes;
- It is possible that the embryo shell will be thinned using assisted hatching to improve implantation;
- At the time of embryo transfer, my/our embryo(s) will be placed in the uterus of the Gestational Carrier;
- There is no guarantee that a pregnancy will be achieved following this treatment.

Please initial (if applicable) :

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|-----------------------------|----------------------------|-----------------------------|----------------------------|
| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |
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OR


IVM (*in vitro* maturation)

I/we consent to undergo IVM treatment in order to create embryos that will be transferred to a Gestational Carrier (Surrogate). I and my partner (if applicable) 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 embryo transfer;
- Medication and anesthesia 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;
- 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 of achieving fertilization of any egg(s). Unfertilized eggs will be disposed of in accordance with standard protocol;
- There is no guarantee embryos will develop normally;
- Before the embryo transfer to the gestational carrier, the embryo shell will be thinned using assisted hatching to improve implantation;
- The embryos created will be reserved for my own/our reproductive purposes;
- At the time of transfer, my embryo(s) will be placed in the uterus of the Gestational Carrier;
- There is no guarantee that a pregnancy will be achieved following this treatment.

Please initial (if applicable) :

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| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |



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 the Quebec government.
- 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)

Please indicate letter of choice :

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|----------------------------------|-------------------------------------|----------------------------------|-------------------------------------|
| _____ <i>Patient Initials</i> | _____ <i>Date YYYY / MM / DD</i> | _____ <i>Partner Initials</i> | _____ <i>Date YYYY / MM / DD</i> |
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Unused Fresh Good Quality Embryos

The number of embryos created may be greater than the number of embryos transferred in a treatment cycle. If there are any remaining embryos that are of sufficiently good quality for freezing, I/we consent to:

- a. Freeze them (cryopreserve) for my/our own future reproductive purposes.
- b. 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.
- c. Dispose of them in accordance with standard protocol.

Please indicate letter of choice :

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|----------------------------------|-------------------------------------|----------------------------------|-------------------------------------|
| _____ <i>Patient Initials</i> | _____ <i>Date YYYY / MM / DD</i> | _____ <i>Partner Initials</i> | _____ <i>Date YYYY / MM / DD</i> |
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Disposition of Unused Poor Quality Embryos

After embryo transfer, if there are excess 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.

Please indicate letter of choice :

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|----------------------------------|-------------------------------------|----------------------------------|-------------------------------------|
| _____ <i>Patient Initials</i> | _____ <i>Date YYYY / MM / DD</i> | _____ <i>Partner Initials</i> | _____ <i>Date YYYY / MM / DD</i> |
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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:

- Donate them to my surviving partner for his/her future reproductive purposes.
- 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.
- Dispose of them in accordance with standard protocol.

Please indicate letter of choice :

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| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |



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:

- Donate them to my surviving partner for his/her future reproductive purposes.
- 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.
- Dispose of them in accordance with standard protocol.

Please indicate letter of choice :

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| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |



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:

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

Please indicate letter of choice :

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| <i>Patient Initials</i> | <i>Date YYYY / MM / DD</i> | <i>Partner Initials</i> | <i>Date YYYY / MM / DD</i> |



I/we 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 surrogacy arrangements and filiation of children born to them;
- I/we must consult a lawyer regarding legal aspects of surrogacy arrangements and filiation of children born of them before treatment can commence;
- I/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 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;
- 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/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 will provide the Clinic information about the outcome (result) of treatment and the outcome of any pregnancy resulting from treatment. I 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 embryos will survive freezing;
- 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;
- 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.

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 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).
- 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.

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| 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. | | | |
| <hr/> <i>Patient Name (Print)</i> | <hr/> <i>Signature</i> | <hr/> <i>Place (City)</i> | <hr/> <i>Date (YYYY/MM/DD)</i> |
| <hr/> <i>Witness Name (Print)</i> | <hr/> <i>Signature</i> | <hr/> <i>Place (City)</i> | <hr/> <i>Date (YYYY/MM/DD)</i> |

| | | | |
|---|------------------------|---------------------------|--------------------------------|
| 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. | | | |
| <hr/> <i>Partner Name (Print)</i> | <hr/> <i>Signature</i> | <hr/> <i>Place (City)</i> | <hr/> <i>Date (YYYY/MM/DD)</i> |
| <hr/> <i>Witness Name (Print)</i> | <hr/> <i>Signature</i> | <hr/> <i>Place (City)</i> | <hr/> <i>Date (YYYY/MM/DD)</i> |