MUHC Reproductive Centre

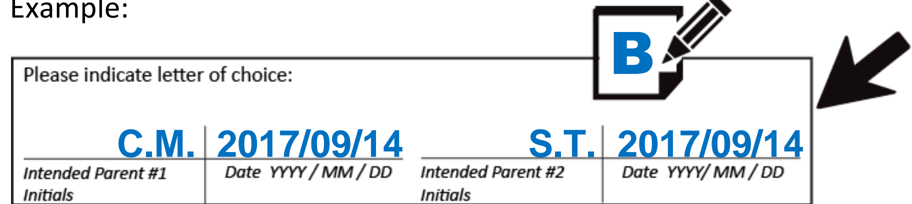
Consent of Commissioning Couple (Intended parent(s)) to IVF using Donor Eggs and Embryo Transfer to a Gestational Carrier (Surrogate)

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:



Consent Signature (page 7):

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 using Donor Eggs and Embryo Transfer to a Gestational Carrier (Surrogate)

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

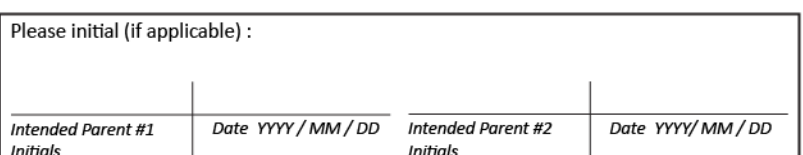
Consent of Commissioning Couple (Intended Parent(s)) to IVF using Donor Eggs and Embryo Transfer to a Gestational Carrier (Surrogate)

Please check the treatment that was ordered by your physician.

☐ In Vitro Treatment

I/we consent to using donor eggs from either a donor or an egg bank for in vitro fertilization (IVF) with donor eggs and transfer to a Gestational Carrier (Surrogate). I and my partner (if applicable) have been informed that:

- Treatment may be cancelled at any stage between the donor's ovarian stimulation cycle and the embro transfer. I/we will be informed of the reason(s) for cancellation;
- If using an egg donor, 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) :

Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

Sperm that will be used to fertilize eggs will be:

a. The sperm of both partners.

____________________________ ____________________________

Partner Full Name Partner Full Name

b. The sperm of one partner.

____

Partner Full Name

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:

Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

Eggs to be fertilized will be:

a. From a donor egg bank.

____________________________ ____________________________

Name of Egg Bank *Code*

b. From a designated donor.

____________________________ ____________________________

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

c. From an anonymous donor.

____

Source

Please indicate letter of choice:

Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

Gestational Carrier (Surrogate)

The embryo(s) will be transferred to the uterus of the gestational carrier who will carry the pregnancy:

______________________________	______________________________
Gestational Carrier Full Name	Date of birth (YYYY/MM/DD)

Please initial:

Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

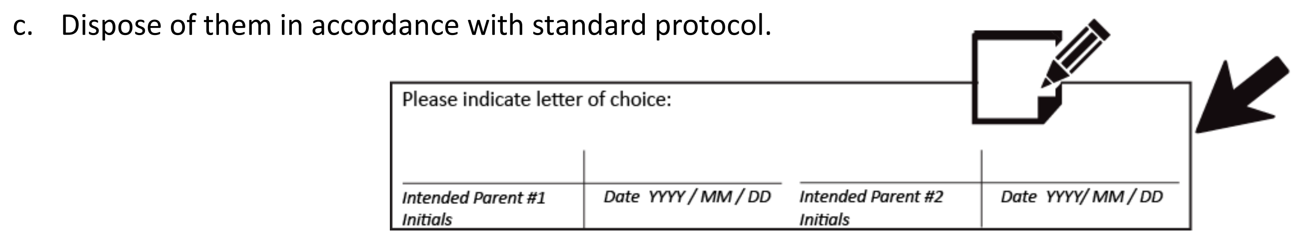
Unused Fresh Good Quality Embryos

The number of embryos created may be greater than the number of embryos transferred in a treatment cycle. In accordance with my/our donor's wishes, 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:

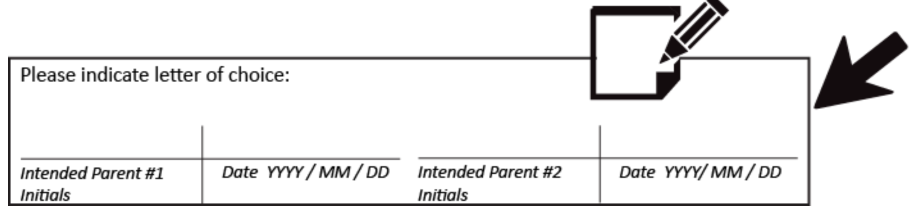
Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

Disposition of Unused Poor Quality Embryos

In accordance with my/our donor's wishes, 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:

Intended Parent #1 Initials	*Date YYYY / MM / DD*	*Intended Parent #2 Initials*	*Date YYYY/ MM / DD*

Frozen Embryos — In the Event of Death

Intended parent #1 :____

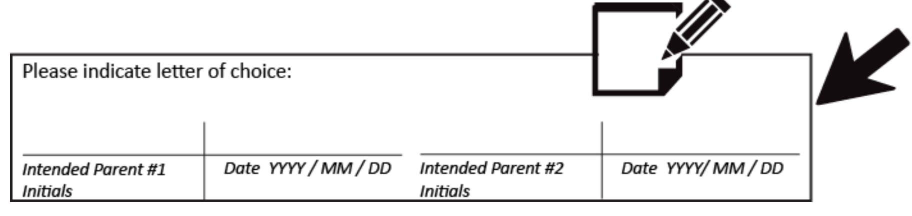
Full Name of Intended Parent #1

In accordance with my/our donor's wishes, 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.


Please indicate letter of choice:

Intended Parent #1 Initials	Date YYYY / MM / DD	Intended Parent #2 Initials	Date YYYY/ MM / DD

Frozen Embryos — In the Event of Death

Intended parent #2 (if applicable): ____

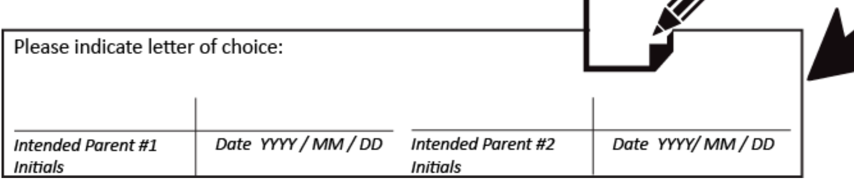
Full Name of Intended Parent #2

In accordance with my/our donor's wishes, 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.


Please indicate letter of choice:

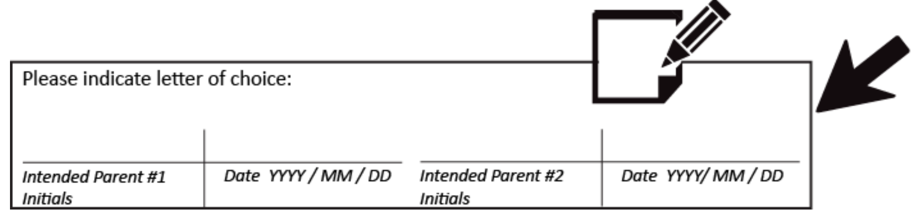
Intended Parent #1 Initials	Date YYYY / MM / DD	Intended Parent #2 Initials	Date YYYY/ MM / DD

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

Couple's Choice (if applicable)

In accordance with my/our donor's wishes, In the event of our simultaneous death, if there are remaining frozen embryos in storage, I/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.



Please indicate letter of choice:

Intended Parent #1 Initials	Date YYYY / MM / DD	Intended Parent #2 Initials	Date YYYY/ MM / DD

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).
- 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.

INTENDED PARENT #1 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.

Name Intended Parent #1 (Print)	_Signature_	_Place (City)_	_Date (YYYY/MM/DD)_
Witness Name (Print)	_Signature_	_Place (City)_	_Date (YYYY/MM/DD)_

INTENDED PARENT #2 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.

Name Intended Parent #2 (Print)	_Signature_	_Place (City)_	_Date (YYYY/MM/DD)_
Witness Name (Print)	_Signature_	_Place (City)_	_Date (YYYY/MM/DD)_