Signature of Consultant:

Signature of the Male partner:

Signature of the Female partner:

CONSENT FORM FOR CRYOPRESERVATION AND STORAGE OF HUMAN OOCYTE

I, _____, age _____a married / unmarried female, (circle one)
(Female name)

residing at _____ _____
(female's address)
_____ do
hereby

request the cryopreservation and storage of my oocytes by IHR for use in an In Vitro Fertilization (IVF) procedure / ICSI

I. PROCESS

I understand that

a. In order to produce multiple oocytes I shall need to undergo controlled ovarian hyperstimulation (COH) using a prescribed gonadotropins (injectable medications).

b. I will be monitored on a regular basis with vaginal ultrasound examinations and serial blood sampling (if necessary).

c. Upon attainment of desired degree of ovarian stimulation, ovulation will be triggered by injection of human chorionic gonadotropin (hCG) or GnRH-agonist followed by transvaginal ultrasound guided needle follicule aspiration (i. e. oocyte retrieval)under general anaesthesia.

d. The objective is to safely obtain as many, good quality, mature ("MII") oocytes as possible. Following oocyte retrieval all suitable MII oocytes will be frozen by a process called vitrification (rapid freezing technique).

II. RISKS ASSOCIATED WITH OOCYTE STORAGE

It is generally accepted that cryopreservation and storage of oocyte is anuseful and safe procedure, which maintains the potential reproductive function of human oocyte after storage in liquid nitrogen.

I understand that

a. I will be taking injectable medication(s) (gonadotropins) on a specific schedule to stimulate my ovaries (COH) which may potentially produce temporary enlargement and cyst of my ovaries.

b. Side effects sometimes encountered with enlargement of the ovaries and the growth multiple follicles may be pelvic discomfort, bloating, nausea, fatigue and occasionally mood swings.

c. Rarely the physical changes in the ovaries could produce severe complications, such as twisting or rapture of an ovary, which may require surgical intervention, or metabolic problems (such as ovarian hyperstimulation syndrome) that could require subsequent hospitalization and additional expenses

d. As a result of taking this medication(s), there is a chance that I would be required to restrict strenuous and /or sexual activity for 1-4 weeks thereafter.

Signature of Consultant:

e. There is a risk of Laparoscopy during Ultrasound Direct Follicle aspiration.

f. There is also the possibility that none of my oocyte will survive the cryopreservation procedure.

g. There is no guarantee that a pregnancy will result from the use of my cryopreserved oocyte.

h. If a pregnancy should occur from future use of any or all of my cryopreserved oocyte, the same complications of pregnancy and childbirth could occur as with a pregnancy resulting from sexual intercourse such as ectopic pregnancy, miscarriage and abnormal baby.

i. Unforeseen occurrences such as natural disasters could result in the loss of one or all of my stored oocytes at IHR. I understand that IHR and its staff cannot guarantee against all possible factors that might result in specimen loss, and therefore, I hold harmless IHR, its staff, consultants, heirs, directors, and/or owners under such circumstances.

III. OOCYTE DISPOSITION

a. I (we) understand that IHR has set a storage limit of five years (from the date of cryopreservation). If at the end of the five years period, I (we) have not utilized the cryopreserved samples, I (we) agree that IHR may dispose the cryopreserved samples in manner as agreed by me in this consent form.

Signature of the Male partner:

○Discard ○Donate

1. b. I acknowledge that I am financially responsible for the freezing and storage of the oocyte and should I fail to pay the freezing & storage fees in time, (annually) the oocyte will be disposed of in manner as agreed by me in this consent form. The institute shall make all the attempts to give reminder for the renewal of the oocyte but it is the sole responsibility of the patient to make the renewal payment on time. A late fee of Rs. 100/- (rupees hundred only) per day shall be charged.

○Discard ○Donate

c. I understand that all storage fees must be paid in advance on annual basis. It is my responsibility to contact IHR prior to the expiration stipulated time and to deposit the storage charges in time.

Signature of the Female partner:

d. In the event of my death, the IHR is authorized to do the following with mysample.

○Discard ○Donate

- Comply with any decisions of my surviving husband.(hold true if married)
- …… (any other person)

e. In the event of death of me and my husband, the IHR is authorized to do the following with my sample.(hold true if married)

○Discard ○Donate

- …… (any other person)

f. Testing of HbsAg, HIV I, II, HCV, VDRL must be negative within 6 (six) months of sample preservation willingly authorize IHR to draw and test my blood for presence of above infectious agents. I understand and agree that if my blood tests positive for any or all of the above infectious agent, IHR reserves the right to immediately dispose of all fresh or frozen oocyte samples in its possession. Thus, this terminates the Storage Agreement.

g. I have preserved _____ oocytes with IHR. (Patient Signature - _____)

h. This Agreement is effective from _____ to _____

IV. AUTHORIZATION

I authorize ……

Name	Signature	Address
a.		
b.		
c. None		

for release of my cryopreserved oocyte sample(s) in my absence

VI. All the above points are well explained to me by Dr. _____in the language which I can understand and one copy of this form is handed over me. A copy of this consent form is available for the patient on request.

Female Partner Signature
Name:

Parent/Guardian Signature
(If under 18 years of age)
Name:

Male PartnerSignature
Name:
Address:

Consultant Signature
Name:

Email Address
Phone: