



Atlantic Assisted Reproductive Therapies
Suite 213, 1535 Dresden Row
Halifax, NS B3J 3T1

CONSENT TO UNDERGO A TREATMENT CYCLE OF IN VITRO FERTILIZATION (IVF)

In Vitro Fertilization (IVF) is a process in which one or more oocytes (eggs) are removed from the prospective mother's ovary and placed in a culture dish to be fertilized by the prospective father's sperm. If the fertilization attempt is successful, cell division will begin. When the resulting embryos are between 2 and 6 days old, between 1 and 3 are transferred into the mother's uterus. Embryos that reach the blastocyst stage (usually on day 5) show a higher implantation potential, however, to reach this stage requires "extended culture". This will need your consent, which may be given verbally as late as day three.

I/we have read the information documents entitled "In Vitro Fertilization and Embryo Transfer". And the "Impact of Multiple Pregnancy". In Signing this consent, I/we agree to the procedure of the In Vitro Fertilization and Embro Transfer and understand the following:

1. The current success rate of this procedure ranges from 40 to 60 percent per cycle of therapy for women under the age of 40. Therefore, there is no guarantee of success as demonstrated by uterine pregnancy.
2. The rate of congenital anomalies appears to be no higher in In Vitro Fertilization than that found in infants conceived naturally. As with any pregnancy, no guarantee can be given that the fetus (child) will be normal.
3. The action and potential side effects of medications used to stimulate ovulation have been explained to me/us. In particular, I/we are aware of the 1-3% risk of ovarian hyperstimulation syndrome as outlined in the AART IVF Information Brochure.
4. Recovery of the eggs from the ovary requires sedation and a procedure called a transvaginal oocyte retrieval. Its potential risks have been explained to me/us including hemorrhage (bleeding), trauma, and infection. I/we are also aware that sometimes no oocytes (eggs) are obtained from the oocyte retrieval.
5. The technique of embryo transfer has been explained.
6. The risks of IVF include:
 - a) multiple pregnancy is approximately 40% including triplets and rarely quads or more;
 - b) 8-12% of cycles are cancelled before the egg collection procedure;

- c) 1-3% risk of ovarian hyperstimulation syndrome as outlined in the AART explanatory leaflet; and
 - d) 1-3% of ectopic pregnancy (even if only a small remnant of your fallopian tube(s) are left.
7. I/we understand and accept that there is no guarantee of achieving fertilization of any egg(s) and/or continued division of any embryo(s).
 8. If the ICSI technique is being used, we have read and signed the separate ICSI information brochure and consent form.
 9. In special circumstances where the need for ICSI is not identified until the day of retrieval as the result of a poor sperm quality, I/we consent to convert to ICSI on the labs recommendation and to pay the additional cost.
 10. We understand that there is no guarantee that a pregnancy will be achieved as a result of this treatment. We also understand that there is a risk of miscarriage and/or stillbirth.
 11. I/we understand that the larger the number of embryos transferred, the greater the risk of multiple pregnancy and the higher the risk of high order multiple pregnancy (triplets or more).
 12. I/we understand that the chance of problems developing during pregnancy are greater if a multiple pregnancy occurs. This in large part relates to preterm birth with possible need for newborn intensive care, development delay, or even death.
 13. We agree to inform AART of the outcome of treatment and the outcome of any pregnancy resulting from treatment.

I/we, the undersigned, understand the implications of In Vitro Fertilization as summarized above (and explained to me/us) and accept the responsibility for the decision to have this medical treatment.

I/we consent to use my/our reproductive material (egg and/or sperm) to create an In Vitro Embryo for my/our own reproductive use. If any In Vitro Embryo(s) are created from my/our reproductive materials, I/we further consent to use these In Vitro Embryo(s) for my/our reproductive use.

I/we consent to any spermatozoa or seminal fluid that is not required for the purpose of creating embryos for our own reproductive use to being used for quality control, technical improvement or training purposes at AART including short-term cryopreservation for no more than thirty (30) days, that will not involve the creation of embryos.

I/we consent to the use of immature oocytes or abnormal embryos that cannot be used for our own reproductive purposes, to be used for quality control, technical improvement, or training for AART purposes, including short-term cryopreservation for not more than thirty (30) days, provided that embryonic development is not allowed to go beyond the blastocyst stage and all oocytes and embryos will be destroyed upon completion of this work.

Patient: _____ Partner: _____

Witness: _____ Date: _____