



Informed Consent for Oocyte (Egg) Cryopreservation

Patient Information:	
Patient Name:	Date of Birth:

Part 1:

I have requested to be treated at The Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine (CRM) of Weill Cornell Medical College. I understand that there are several steps involved in the ovarian stimulation, oocyte retrieval and oocyte cryopreservation procedures. I will receive medications to induce the maturation of multiple oocytes; during this time I will undergo multiple blood tests and ultrasound (sonogram) procedures to determine my response to these medications. I will undergo an oocyte retrieval procedure by vaginal ultrasound-guided needle aspiration under intravenous sedation or general anesthesia. Follicles that are evident on ultrasound will be aspirated; follicular fluid and oocytes will be collected. My oocytes will be prepared and cryopreserved, for my own future use.

I understand that CRM suggests that I consult with a CRM staff psychologist in advance of proceeding with oocyte cryopreservation.

1. Ovulation Induction

I understand that a variety of medications are available for the induction of ovulation, including Clomiphene Citrate (Clomid/Serophene), Human Menopausal Gonadotropins (e.g., Menopur), Follicle Stimulating Hormone (e.g., Gonal-F/Follistim/Bravelle), Leuprolide Acetate (Lupron), GnRH-antagonists (Ganirelix/Cetrotide), Letrozole, Estrogen Patches (Climara/Vivelle), and Human Chorionic Gonadotropins (hCG). I understand that these medications are given orally or by intramuscular or subcutaneous injection, which may cause bruising and discomfort at the injection site. Lupron may result in side effects, including fatigue, muscle and joint pain, and transient menopausal-like symptoms (headaches, hot flashes, mood swings, sweats, insomnia, fatigue, etc.). Clomiphene Citrate may result in side effects including hot flashes, abdominal distention, bloating, headache, and visual changes. Gonadotropins (Menopur/Gonal-F/Follistim/Bravelle) may have side effects including a situation where the ovaries become over-stimulated, leading to a condition called Ovarian Hyperstimulation Syndrome (OHSS). In the most severe form of OHSS, serious complications may result, which may require hospitalization and medical intervention. Reported complications, while rare, include ovarian torsion (twisting of the ovary), blood clots, kidney failure, fluid overload, and death. I, therefore, understand the importance of maintaining close contact with the CRM team during the period of time while I receive these medications and for a minimum of two weeks afterwards. Furthermore, some, but not all, studies have suggested that fertility medications might increase the risk of developing ovarian cancer.

2. Monitoring Protocol

I understand that while receiving the medications described above, I will be closely monitored by the CRM team. This monitoring may be as frequent as daily and carries the risk of mild discomfort and bruising at the venipuncture (blood draw) site. I understand that transvaginal ultrasound examinations will be performed, as necessary, and that there may be some discomfort with this procedure. There is no apparent medical risk associated with the use of transvaginal ultrasound. I understand that if monitoring suggests a low probability for successful oocyte retrieval, my stimulation cycle may be stopped and no oocyte retrieval will be performed. Alternatively, if my response to the medications is too high, and the likelihood of hyperstimulation is increased, the stimulation medications may be discontinued and the cycle canceled.

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3. Oocyte Retrieval understand that at a time determined by the CR patient. Oocyte retrieval will be performed by transmesthesia will be administered during the processpirated. The follicular fluid will be analyzed under	insvaginal ultrasound guided needle cedure. The vaginal wall and ova	e aspiration of the follicles. I understand that ry will be punctured and the follicular fluid
Risks related to this procedure include infection necessary in order to administer intravenous a necessary. In rare circumstances, observation in surgery) may be required to stop the bleeding and notlude an allergic reaction, low blood pressure, na	intibiotics. If bleeding occurs, stite in the hospital, a blood transfusion a d repair the injury. The risks of the	ching of the vaginal puncture site may be nd/or laparoscopy or laparotomy (abdomina use of anesthesia during the oocyte retrieva
For a few patients the ovaries may not be acces required to perform the oocyte retrieval. This will be		nd laparoscopy or other procedure would be
understand that there is no guarantee that oocyte	es will be retrieved.	
understand that following the oocyte retrieval, I are normal). I understand that if I experience sever, I should contact CRM immediately at 646-962-2	vere abdominal pain, heavy bleeding	
Please see the Weill Cornell Physicians Notice of may be contacted for follow-up.	Privacy Practices regarding your pro	otected health information. I understand tha
have been encouraged to ask questions, and a understand that any future questions I might have,	<i>y</i> ,	,
Patient Signature	 Date	 Date of Birth





Part 2: Informed Consent for Oocyte (Egg) Cryopreservation

Patient Information:	
Patient Name:	Date of Birth:

Oocyte Cryopreservation

I understand that once the Embryology Team has identified the oocytes, the oocytes will be cryopreserved by vitrification. The cryopreserved oocytes will remain stored in the CRM Embryology Laboratory.

Use of Oocytes

I understand that when I am ready to attempt to achieve a pregnancy, some or all of my cryopreserved oocytes can be thawed. I understand that there is no guarantee that any of the oocytes will survive the freezing and thawing procedure, fertilize or produce a baby. The live birth rate per oocyte thawed using these cryopreservation techniques depends on the age at which the oocyte(s) were cryopreserved.

I understand that the oocyte(s) will be fertilized with a sample of my partner's or my chosen donor's sperm. I understand that intracytoplasmic sperm injection (ICSI) will be utilized to achieve fertilization. I understand that I may receive hormonal medications to mature the lining of my uterus in preparation for embryo transfer as well as antibiotics to prevent infection from the embryo transfer. I understand that I will undergo blood testing and vaginal ultrasound examination to determine my response to these medications as well as the proper time to perform the oocyte thaw, fertilization and embryo transfer. I understand that the embryo transfer will occur by placing the embryos into the uterus via a catheter (a thin, flexible tube) placed through the cervix.

I understand that this process may result in more embryos than can be transferred in one cycle. In some cases, the embryos may be of sufficient quality to be cryopreserved for use in a future cycle. The CRM team will advise on appropriate follow-up.

I understand that it is recommended that I utilize modern prenatal care, which may include chorionic villus sampling (CVS) or amniocentesis.

I understand that the thaw, fertilization and embryo transfer procedures described above are the current standards of practice and that CRM cannot guarantee what the standards of practice will be when I choose to utilize my cryopreserved oocytes.

I understand that the thaw, fertilization and transfer of previously cryopreserved oocytes will require additional consent documents at the time of the procedures.

Discarded Material

I understand that any unused biological material, including cells, blood, follicular fluid, immature oocytes and/or nonviable oocytes, will be discarded after the oocyte retrieval. This material, which would normally be discarded, may be used for training purposes and/or research; no embryos or pregnancies will be generated. I understand that to protect my privacy, all identifiers associated with the biological material will be removed prior to its use for training purposes and/or research. I understand that I may, at any time, decline donation of this material, without prejudice.

1305 York Avenue, 6th Floor, New York, NY 10021 | T. 646.962.2764 | F. 646.962.0359

Patient Information: Patient Name:	Date of Birth:
r duent Nume.	Bate of Birth.
Please indicate your choices	below in each of the items listed:
I hereby <u>CONSENT</u> to a they are discarded. I hereby <u>DO NOT CONSEMENT</u>	is material for quality control and training. allow the clinic to utilize the unused biological material for quality control and training purposes before OR SENT to allow the clinic to utilize the unused biological material for quality control and training carded. This material will be discarded in accordance with normal laboratory procedures and
I hereby <u>CONSENT</u> to	is material for research. allow the clinic to utilize the unused biological material for research. None of this material will be ou sign a specific research consent form. OR
	<u>ASENT</u> to allow the clinic to utilize the unused biological material for research. This material will be normal laboratory procedures and applicable laws.
 (transferred into myself or int Discarding the cryopreser Donating the cryopreser Donating the cryopreser 	not to or am unable to use these cryopreserved oocyte(s) for my own reproductive purposes o a gestational carrier), current alternatives include:
A. In the event of my death In this event, I elect to:	or incapacitation, the ownership of and/or rights to the cryopreserved oocyte(s) shall revert to CRN
3 1	d oocyte(s) d oocyte(s) for research purposes d oocyte(s) to a designated individual Name Address Telephone Email
details and individual designation	ndividual is unable or unwilling to accept the cryopreserved oocyte(s), the clinic will determine the ation of any donation. I agree that, if it is not possible to carry out my chosen option and/or I cannot be tastrophic event occurs, the clinic is authorized to discard my cryopreserved oocyte(s).

Patient Information:	
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Discard the cryopreserveDonate the cryopreserveTransfer the cryopreserve	d oocyte(s) for research purposes ed oocyte(s) to a designated storage facility at my expense d oocyte(s) to a designated individual Name Address Telephone
In the event the designated in details and individual designation	Email Individual is unable or unwilling to accept the cryopreserved embryos, the clinic will determine the ation of any donation.
be made to abide by your wis donated to another individual	r research or to another individual may not be possible or may be restricted by law. While efforts will shes, no guarantees can be given that your cryopreserved oocyte(s) will be used for research or . In these instances, if your oocyte(s) are not eligible or we cannot abide by your wishes, your be destroyed and discarded by the lab in accordance with laboratory procedures and applicable laws.
	sociated with ovarian stimulation and oocyte cryopreservation are my responsibility. I understand tha act the CRM Billing Department regarding fees.
	nsible for paying quarterly fees to CRM in order to continue the storage of my cryopreserved CRM with an updated address and telephone number when I move.
contact me after reasonable	essociated with oocyte storage have not been paid for a period of one (1) year and CRM is unable to efforts have been made (via registered mail at last known address), my cryopreserved oocyte(s) may ordance with normal laboratory procedures and applicable law.
purposes as a result of nonpa	2-8.7 (f), reproductive tissue stored for a client-depositor shall not be destroyed or released for other ayment of storage fees or for any other reasons, without documentation that the client-depositor was a notice by certified mail, return receipt requested
	ask questions, and any questions that I have asked have been answered to my satisfaction. I also uestions I might have, will be answered by a member of the CRM team.
Patient Signature	

Oocyte Cryopreservation-Part 2