40648

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR THE USE OF ANONYMOUS DONOR SPERM (ADS)

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

I _____ and _____
(print patient's full name) (print partner's full name, if applicable)

are being treated at Women & Infants Fertility Center (WIFC) for the purpose of achieving a pregnancy.

I/we have considered the available options for achieving parenthood, including procedures that are not performed at WIFC, and other non-medical options such as adoption or non-treatment, and have chosen to attempt pregnancy using the sperm of an anonymous donor:

Donor Bank: _____

Donor Number: _____

I/we understand that there is no guarantee that pregnancy will occur by using donor sperm.

I/we understand that there are potential risks associated with using donor sperm, including the possibility that infection could be introduced into the person being inseminated.

I/we understand that this procedure involves purchasing sperm from a donor sperm bank and using the sperm for my/our treatment.

I/we understand that anonymous donor sperm sample(s) must be frozen by a sperm bank outside of WIFC that is licensed with the American Association of Tissue Banks (AATB) and registered with the Food and Drug Administration (FDA). I/we understand that WIFC will not use the donor sperm if the sample does not meet these requirements.

I/we understand that the donor sperm sample(s) must be delivered to WIFC's Andrology Laboratory prior to the treatment cycle.

I/we understand that the same types of pregnancy or delivery complications can occur using sperm from an anonymous donor as with a pregnancy achieved by sexual intercourse or fertility treatment using the partner's sperm. It is also possible that the resulting child(ren) are born with abnormalities, abnormal traits, disabilities or hereditary tendencies from either biological parent, as could a child who was conceived by sexual intercourse.

I/we accept and acknowledge my/our obligation to the child(ren) born from the use of donor sperm, and agree to care for, support and otherwise treat any child(ren) born as a result of this procedure, in all respects, as if it/they were my/our naturally conceived child(ren).

I/we understand that federal regulations and reporting requirements obligate WIFC to provide the Centers for Disease Control with cycle-specific data regarding the treatment cycle and the pregnancy outcome. However, I/we understand that any and all personal identifiers associated with this treatment will be protected under the Privacy Act. Information obtained and identified with me/us during this procedure will remain confidential and will not be disclosed, except to authorized employees of the Rhode Island State Department of Health or other government agencies with my/our permission.

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WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

I/we acknowledge that this form has been explained to me/us and I/we understand its contents. I/we have had the opportunity to ask questions which have been answered to my/our satisfaction.

Time: _____ A.M./P.M. Date: _____ Signature: _____
Patient

Time: _____ A.M./P.M. Date: _____ Signature: _____
Partner (if applicable)

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by this patient (and partner, if applicable)

Time: _____ A.M./P.M. Date: _____ Signature: _____
(Provider)

Print Name:_____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (and partner, if applicable)

Time: _____ A.M./P.M. Date: _____ Signature: _____
(Interpreter)

Print Name:_____
(Interpreter)