40649

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR THERAPEUTIC USE OF DIRECTED DONOR SPERM -SUBSEQUENT USE

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 ______________________________ are treating at
(print patient's full name) (print partner's full name, if applicable)

the 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 a directed (known) donor.

I/we understand that there are many steps involved in the use of directed donor sperm, including cryopreservation of the directed donor's sperm samples, adequate quarantine of these sperm samples (as directed by the regulatory agencies), approval by the clinical and psychological staff of WIFC, proper completion of the informed consent process and using the sperm for intrauterine insemination (IUI) or in vitro fertilization (IVF).

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

I/we also understand that there are potential risks associated with this procedure, including the possibility that infection could be introduced into the patient.

I/we understand that in some cases, the birth of a child by use of known donor sperm can produce psychological problems for me/us, my/our family, the donor, the donor's family, or the child(ren).

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

I/we understand that I/we are responsible for having the sperm sample(s) delivered to WIFC's Andrology Laboratory prior to the treatment cycle.

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

I/we accept this act as my/our own, and acknowledge my/our obligation to the child(ren), and agree to care for, support and otherwise treat the child(ren) born as a result of this procedure, in all respects, as if my/our naturally conceived child(ren).

I/we understand that I/we may be contacted for a follow-up consultation by WIFC.

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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.

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)