40651

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR INTRACYTOPLASMIC SPERM INJECTION (ICSI)

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 name) (Print Partner's name, if applicable)

consent for the embryology staff at Women and Infants Fertility Clinic (WIFC) to perform intracytoplasmic sperm injection (ICSI). I/we understand that ICSI is a procedure where a single sperm is placed directly into the oocyte (egg) using a microscopic needle in an effort to increase the likelihood of fertilization. The clinical decision to proceed with ICSI is made by the physician/embryology staff based on sperm and/or egg quality and/or quantity.

I/we understand that ICSI may be performed in the event of any of the following, and as deemed necessary by the WIFC team to improve the chances of achieving pregnancy:

- low sperm count
- low sperm motility (speed)
- poor sperm shape/size
- use of frozen sperm
- use of donor sperm
- use of surgically retrieved sperm
- past history of sub-optimal fertilization in a prior IVF cycle
- low egg yield
- use of donor eggs
- use of cryopreserved (frozen) eggs.

There may be other indications where ICSI may be justified, including in pre-implantation genetic testing.

The risks and benefits of ICSI have been discussed with me/us, and I/we understand them. I/we understand that complications can happen as a result of ICSI. Complications include, but are not limited to the following:

- Failure of fertilization – I/we understand that there is no guarantee that fertilization will occur. If fertilization fails, I/we understand that pregnancy will not occur in this cycle.
- Birth defects and ICSI – My/our physician has explained that some literature suggests that there may be an increased risks of birth defects in children conceived from ICSI compared to those conceived with traditional IVF (or naturally). It is also possible that any already existing genetic conditions or problems with the chromosomes of the sperm (such as those that may be associated with abnormal sperm) may be passed on to male children born from ICSI.
- Damage to the egg(s)

I/we understand that ICSI, as well as all assisted reproductive technologies, may increase the chances of

multiple gestations (more than one baby), including identical and non-identical twin pregnancies.

I/we are aware that the practice of medicine is not an exact science. I/we acknowledge that no guarantee or promise has been given to me/us by anyone as to the results of this procedure.

I/we acknowledge and agree that I/we are responsible for all costs and fees for ICSI.

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 the 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 the patient (and partner, if applicable.)

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

Print Name:_____
(Interpreter)

For Partner's Signature if not signed at WIFC

STATE OF _____
COUNTY OF _____

Then personally appeared before me the above named _____, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of _____, 20____.

NOTARY PUBLIC: _____
MY COMMISSION EXPIRES: _____