4.1 Consent Form to be signed by the Couple

We have requested the Centre (named above) to provide us with treatment services to help us bear a child.

We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries to raise oocytes have temporary side effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyper-stimulation occurs, where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent, in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

2. There is no guarantee that:

   a. The oocytes will be retrieved in all cases.

   b. The oocytes will be fertilized.

   c. Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.

   All these unforeseen situations will result in the cancellation of any treatment.

3. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are replaced.

4. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.

5. **Endorsement by the ART clinic**

   I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

6. This consent would hold good for all the cycles performed at the clinic.

Name and Signature of the Husband

Name and Signature of the Wife

Name, Address and Signature of the Witness from the clinic

Name and Signature of the Doctor

Dated: