4.6 Consent for Oocyte Retrieval/Embryo Transfer

Woman's Name:

Woman's Address:
Name of the Clinic:

I have asked the Clinic named above to provide me with treatment services to help me bear a child. I consent to:

a) Being prepared for oocyte retrieval by the administration of hormones and other drugs

b) The removal of oocytes from my ovaries under ultrasound guidance/ laparoscopy

c) The mixing of the following:

☐ My oocytes ☐ the sperm of my husband

☐ Anonymous donor oocyte ☐ anonymous donor sperm

(Tick the appropriate and strike off the others)

d) the placing in my _____ of

e) 1. _____ (no) of the oocytes mixed with the sperm

f) 2. _____ (no) of the resulting embryos

g) 3. _____ (no) of our cryo-preserved embryos

h) 4. _____ (no) of embryo (s) obtained anonymously

I had a full discussion with _____ about the above procedures and I have been given oral and written information about them.

I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general/regional/sedation) has been discussed in terms which I have understood.

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.

Signature of Female Partner

Name, Address and Signature
of the Witness from the clinic

Name and Signature of the Doctor

Dated