California Center for Reproductive Health

CONSENT TO THAW AND TRANSFER CRYOPRESERVED EMBRYOS

I, _____ (Female Partner) and _____ (Partner, Spouse) wish to use cryopreserved (frozen) embryos to achieve pregnancy by undergoing a frozen embryo transfer (FET) cycle. I/We understand that achieving pregnancy using cryopreserved embryos requires the preparation of the uterus (in a medicated or natural menstrual cycle), followed by the thawing of embryos and embryo transfer into a recipient's (Female Partner or gestational surrogate) uterus. I/We acknowledge that embryo survival after thawing cannot be guaranteed, nor can pregnancy be guaranteed following embryo transfer if embryos survive the thawing process. I/We consent to allow the California Center for Reproductive Health (CCRH), its affiliate laboratory, and physicians to thaw our cryopreserved embryos for the purpose of embryo transfer and pregnancy.

Procedural Overview
I/We understand that in a FET cycle the uterus must be prepared for implantation for several weeks (typically 2) prior to thawing of embryos and embryo transfer. In a medicated FET cycle this is normally first achieved using estrogen in the form of oral tablets, intramuscular injections, or transdermal patches. Several days prior to embryo thawing and transfer progesterone is added in the form of vaginal suppositories or intramuscular injections. The purpose of estrogen treatment is to thicken the endometrial lining (the inside lining of the uterus) and make it receptive to embryos, while progesterone serves to prepare the uterus for embryo implantation. In a medicated FET cycle, both estrogen and progesterone administration continues through the 9th to 10 weeks of gestation. Additional medications used in a FET cycle may include medications to suppress ovulation, low dose oral corticosteroids, along with a low dose aspirin tablet. Estrogen and progesterone treatment may cause mild mood changes, bloating, breast tenderness, and fatigue. Side effects are rare after treatment with steroids but low dose oral steroids can cause acne, blurred vision, sleep disturbance, muscle weakness, stomach upset, bloating, and irritable mood. Monitoring for a FET cycle, will include frequent blood drawing and transvaginal ultrasounds.

Assisted Hatching
Assisted hatching (AH) is a specialized laboratory procedure whereby the shell surrounding the embryo, called the zona pellucida, is weakened using micromanipulation instruments in order to facilitate the hatching (release from its shell) of the embryo(s), so as to improve the chance of implantation in the uterus. Multiple studies have suggested improved implantation rates of frozen-thawed embryos undergoing assisted hatching prior to embryo transfer. The risks associated with assisted hatching include the potential of increased incidence of multiple gestations, and the possible damage/destruction of the embryos. A separate consent for Assisted Hatching must be signed before thawing of embryos and embryo transfer.

My initials indicate that I consent to assisted hatching of frozen-thawed embryos: _____ _____
Initials

Embryo Transfer
I/We understand that there is no guarantee than any embryo will survive the thawing process and that if no embryos survive the thaw, the embryo transfer will be canceled.

The embryo transfer procedure involves the placement of a catheter containing thawed embryo(s) into the uterine cavity through the cervix (opening to the womb). Occasionally frozen-thawed embryos may be transferred into the fallopian tubes in a procedure called zygote intrafallopian transfer (ZIFT), or tubal embryo transfer (TET). Trans-cervical embryo transfer may lead to minimal to no discomfort, and on occasion scant vaginal bleeding. A separate consent for Embryo Transfer must be signed before thawing of embryos and embryo transfer.

My initials indicate that I consent to embryo transfer of frozen-thawed embryos: _____ _____
Initials

I/We understand that there is no guarantee that any of the frozen-thawed embryos transferred will result in a pregnancy. I/We understand that as in any assisted reproductive technique (ART) treatment, the transfer of a single or multiple embryo(s) into the uterus in a FET cycle may result in a risk of multiple gestation (more than one baby). The risks of multiple gestations include, but are not limited to, preterm labor and the delivery of premature infants who may require prolonged hospitalization and who may have long-term complications associated with prematurity. It is CCRH's policy to limit the number of embryos transferred according to maternal age and embryo quality in order to maximize success rates and minimize the risk of a multiple gestation.

I/We understand that pregnancies resulting from FET are subject to the same complications as pregnancies achieved with standard in vitro fertilization (IVF)/embryo transfer and those achieved without medical intervention, such as miscarriage, ectopic pregnancy, preterm labor, or other complications. There may be a risk of infants having developmental problems or congenital birth defect as a result of any ART treatment, including embryo cryopreservation and thawing/transfer; however, initial human experience and extensive experience in domestic animal species have not yet demonstrated an increase in developmental or congenital anomalies in

offspring born following cryopreservation beyond that observed in other ART treatments (such as IVF and embryo transfer). I/We understand that the health of any infant resulting from this procedure cannot be guaranteed. Separate consents for Assisted Reproductive Techniques and Embryo Cryopreservation must be signed before the IVF and embryo freezing procedures.

_____ _____
Initials

RELEASE

I/We agree to absolve, release, indemnify, protect and hold harmless CCRH, its affiliate laboratory, its physicians, officers, directors, agents and employees, from any and all liability, claims or damages including legal fees, arising from any adverse outcome, however remote, resulting from thawing of frozen embryos and frozen embryo transfer including but not limited to the loss or destruction of embryos, the birth of a physically or mentally disabled child or subsequent disputes between the parties regarding the custody and/or support of any children ultimately born as a result of this procedure.

_____ _____
Initials

Certification of Informed Consent for Thawing and Transfer of Cryopreserved Embryos

Your signature below indicates that you have read the preceding consent, that you have had the opportunity to ask questions, and that your questions have been answered to your satisfaction.

PATIENT NAME (print)	**PATIENT SIGNATURE**	**DATE**
PARTNER NAME (print)	**PARTNER SIGNATURE**	**DATE**
WITNESS (print)	**WITNESS SIGNATURE**	**DATE**