

**FAMILY BEGINNINGS/IVF LAB  
RETRIEVAL CONSENT FORM**

The Family Beginnings IVF Lab must obtain your written consent before any medical treatment or laboratory procedure can be performed. This document lists the different procedures that may be used as part of your treatment, indicates which of these procedures will actually be carried out, and confirms that the specific aspects of each treatment and/or procedure have been fully discussed and presented to you. We ask that you sign this document to indicate that you have received all of the information necessary for you to make an informed decision whether to pursue the treatments and/or procedures indicated.

My primary physician is Dr. \_\_\_\_\_.

1. I \_\_\_\_\_ (Donor) hereby authorize and direct the following medical, surgical, or laboratory procedures be performed as part of my treatment in the Family Beginnings IVF Lab program:

\_\_\_\_\_ Oocyte Retrieval

2. I acknowledge that the general nature of my condition(s) has been explained to me, and that any alternative treatment methods have been explained as well as the advantages and disadvantages of each. I understand that the possibility and nature of complications arising from the procedures to be performed cannot be completely anticipated, and thus accept that there are no guarantees, expressed or implied, as to the result of the treatments or procedures to be performed.

3. I acknowledge that I have received written information describing each of the procedures to be performed. I acknowledge that I have had the opportunity to fully review this written information, and that I have had the opportunity to ask either my physician or the laboratory director any questions I may have regarding these procedures, and that my questions have been answered to my satisfaction.

4. For surgical procedures (including transvaginal ultrasound guided oocyte retrieval for IVF), what the most likely complications are, or other undesired results have been explained to me. I understand and have considered these risks. I have also been offered information on less likely complications and/or undesired results, which even though rare, could occur. Such complications may include: infection, blood clots in the legs or lungs, post-operative bleeding, excessive surgical bleeding, possible blood transfusion, fistula formation, bowel obstruction, urethral or bladder injury, injury to other pelvic or abdominal organs, and risks of anesthesia including paralysis, coma or even death.

5. Data from your ART procedure will be provided to the Centers for Disease Control (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that the CDC collect data on all assisted reproductive technology cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, the CDC applied for and received an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308 (d). This means that any information that the CDC has that identifies you will not be disclosed to anyone without your consent.

6. I further understand that factors out of the control of Family Beginnings, P.C. and James Donahue, M.D., e.g. loss of power, mechanical failure, human error or other unavoidable circumstances, may result in loss of oocytes and/or embryos.

7. I hereby state that I have read and understand this consent for, and that any and all questions I have about my procedure(s) have been answered to my satisfaction. By signing this consent form, I provide my consent for the Family Beginnings IVF Lab to perform the procedures indicated above.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU FULLY UNDERSTAND ALL OF THE ABOVE STATEMENTS AND ALL QUESTIONS REGARDING YOUR TREATMENT HAVE BEEN ANSWERED.

\_\_\_\_\_ (Donor)                      Date: \_\_\_\_\_

\_\_\_\_\_ (witness)                      Date: \_\_\_\_\_