Consent to treatment involving egg collection and storage of eggs

About the patient (Please check your details carefully)

First name

Surname

Date of birth

Patient I.D.

Please select as applies to you:*

☐ My/our personal circumstances have not changed since my/our last treatment (e.g. separation or divorce).

☐ My/our personal circumstances have changed since my/our last treatment (e.g. separation or divorce). Please discuss these changes with your consultant.

1 Consent

☐ I (the patient) consent in preparation for my egg collection to: *

- Ultrasound scans
- Relevant blood tests
- Self-administering medication

I (the patient) consent to the removal of eggs from my ovaries with the aid of:

- Ultrasound scans
- Anesthetic and any other necessary drugs
- Laparoscopy

The cryopreservation of my collected eggs

2 Risks of treatment

☐ I confirm that I understand the following: *

- I understand that I need to have had screening for HIV, Hepatitis B and Hepatitis C within 3 months of first treatment (i.e. egg collection procedure or IUI procedure) and every 2 years thereafter for subsequent cycles for the female patient. These tests will be necessary for any male partner in a future Egg Thaw Embryo Transfer cycle.
- I confirm that no travel has occurred for any consenting patient or partner to Ebola or ZIKA-affected areas during time periods outlined in current clinic information or that I have signed the Zika Awareness Patient Consent form.
- I have been made aware that the risks of treatment include, but are not limited to:
  - Ovarian Hyperstimulation Syndrome (OHSS)
  - Cycle cancellation because of over- or under-response to hormone stimulation
  - Uncommon surgical complications associated with egg collection: bleeding, infection, injury to bowel, bladder or blood vessels
- I understand that there is a very low risk of technical problems, such as, equipment failure, which could result in harm or damage to my eggs.

2 Risks of treatment (continued)

- I understand that the Lister Fertility Clinic will take every care to uphold the safety of my gametes whilst they are in the laboratory/ in storage at the centre. I understand that the Lister Fertility Clinic has a duty to inform me of any technical problems that may have affected my care.
- I understand that the Lister Fertility Clinic cannot accept responsibility for any damage that might occur to the eggs as a result of the freezing/ storage/ thawing process.
- I am aware that freezing my eggs does not guarantee my future fertility and should not be seen as a definitive alternative to natural conception.
- I am aware that freezing my eggs should not give me the security to delay natural conception and this would in fact be detrimental to overall chances of conception.
- I am aware that I may need more than 1 cycle of ovarian stimulation to achieve a number of eggs that maximizes potential success.
- I understand that I can request for my eggs to be thawed and that no assurance can be given that the eggs will survive or be suitable for fertilization.
- I am aware of the extra steps involved in egg freezing and the use of frozen eggs that may make success rates less than in standard assisted reproduction cycles for any given age:
    - Stripping of eggs to assess maturity before freezing
    - Process of freezing
    - Process of thawing
    - Need for ICSI treatment to fertilise the eggs
- I understand that there is no guarantee that eggs that have undergone ICSI will fertilise, or that the transfer of any resulting embryos will guarantee a successful outcome.
- I understand that just as with spontaneous pregnancy, there is a risk of foetal malformation and that this risk may be increased following assisted reproduction.
- I understand that the Lister Fertility Clinic cannot accept responsibility for any abnormality or diseases occurring in a child born as a result of fertility treatment in which freezing of eggs has taken place.
- I have been given nationwide and Lister specific success rates and am aware that this data is based on a limited number of women who have thawed their eggs.
- I understand that any suitable eggs can only be stored for an initial period of ten years from the date of cryopreservation.
- I understand that after a period of ten years, there is a possibility of extending the storage period in ten-year increments ONLY if it is shown at any time within each extended storage period that the criteria for extended storage continue to be met (i.e. a medically certified risk of premature infertility). I understand I will need to complete the HFEA LGS form to apply for storage extension and that there is a maximum storage period of 55 years.
- I understand that egg freezing will incur a charge for the freezing process and an additional charge for the thawing and subsequent embryo replacement. I understand that after the first year of storage, I will be invoiced for storage on an annual basis.
- I understand that my stored eggs cannot be transferred from the Lister Fertility Clinic without my consent and that I need to submit the appropriate consent form to the clinic 28 days prior to the desired date of transfer.

3 Declaration

I confirm the following:

- I have received information on the social, ethical and legal aspects, as well as the medical consequences of the procedures outlined above, explained to me in full.
- I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.
- I have had the opportunity to discuss the risks associated with all of the treatment options consented to in this agreement.
- I have been made aware of the alternatives to the procedures outlined above.
- I have been given time to consider the content of this document and I have been given the opportunity to make further enquires as I wish before signing.
- I am aware that both the patient and the partner can make changes to or withdraw their consent at any point until the time of sperm, egg or embryo transfer. If you would like to change or withdraw your consent, you should ask the clinic for a HFEA WC form.
- I understand that I am responsible for contacting the clinic if any of my contact details (phone numbers / address / e-mail) change.
- I declare that the information I have provided in writing is correct and complete.

Date