

## MODEL FORM

[Program's SART Name and Number] \*

### **INFORMED CONSENT FOR IN VITRO FERTILIZATION AND RELATED PROCEDURES**

You are agreeing to undergo a cycle of treatment at [program's SART name]. Do not sign this document if you have not received all of the information listed below or have not met with your physician to discuss the information. Do not allow treatment to begin until after you have given your consent by signing this document.

- a. A **DESCRIPTION** of the treatment
- b. **YOUR CHANCES OF HAVING A BABY** from one cycle of treatment. As part of this explanation, you should have received information about the following:
  1. How successful similar treatments were, on average, for patients across the country in [date/period of time]
  2. How successful similar treatments were, on average, for patients at [program's SART name] in [date/period of time], and why the success rates at this program may be different from the national averages
  3. Any special characteristics you may have that suggest that your chances of having a baby are better or worse than these averages
  4. Your chances of becoming pregnant without any treatment
- c. How **WELL-ESTABLISHED** each component of the treatment is in the field, including whether it is:
  1. Generally accepted within the relevant medical community, or
  2. New and innovative and not generally accepted within the relevant medical community

---

\* The Society for Assisted Reproductive Technology (SART) is an affiliate society of the American Society for Reproductive Medicine. If your program is a current SART member, you can obtain additional information about the program from SART (website: <http://www.sart.org>). If your program is not a current SART member, it does not have a SART number and should not use or be identified by any other program's SART name or number.

- d. How much **EXPERIENCE** [program's SART name] has with each component of this treatment, including the level of training of the professional staff
- e. The **RISKS** of the treatment, including information about the risks of the following:
  - 1. Any drugs that will be prescribed to you, including the possibility of hyperstimulation resulting from taking drugs to induce ovulation
  - 2. The process of removing eggs from your body
  - 3. The process of putting eggs or embryos back into your body
  - 4. Any other problems that might happen because of your treatment and the risks of those problems, *both for you and for your offspring*
  - 5. **MULTIPLE PREGNANCIES** (twins, triplets, etc.) – In discussing the risks of multiple pregnancies, your physician should have given you information about the following:
    - i. Your *chances* of having a multiple pregnancy
    - ii. The *possible health risks* of a multiple pregnancy for both you and your babies
    - iii. *Fetal reduction* (aborting one or more of the fetuses) if you have a multiple pregnancy, including the benefits and risks of fetal reduction
    - iv. Your physician should have explained that your chances of having a multiple pregnancy are higher when more eggs or embryos are put into your body. Although your physician will recommend a specific number of eggs or embryos to transfer, *you may choose to limit the number of eggs or embryos transferred in a treatment cycle* in order to lower your chances of having a multiple pregnancy.
- f. The **GENERAL AMOUNT** that you should **EXPECT TO PAY** for this treatment, including charges that are not covered in the standard fees and the possibility of additional costs related to complications that might occur
- g. What you may choose to do with any **EXTRA EGGS OR EMBRYOS** that are not used during your cycle of treatment

- h. **OTHER TREATMENTS** offered at this program or at other programs, and the **ALTERNATIVES** to these treatments, including **ADOPTION, TRYING TO HAVE A CHILD WITHOUT TREATMENT, and NOT HAVING A CHILD**
- i. Information about **EMOTIONAL AND PSYCHOSOCIAL SUPPORT, INCLUDING PSYCHOLOGICAL COUNSELING**, and a list of resources to obtain psychological counseling

**CONFIDENTIALITY** – Except as required by law, your physician and [program's **SART name**] will not reveal any information about you or your treatment without your consent, except that they may use specific medical details in professional publications as long as personal information about you is not disclosed. Statistics concerning your treatment (without your name or other personal information) will be included in information that [program's **SART name**] provides to the Society for Assisted Reproductive Technology and the federal Centers for Disease Control and Prevention. Any other use of information about you or your treatment would require your specific written consent.

**RESEARCH** – Your physician may use some of your blood or some tissues that would otherwise be discarded (such as follicular fluid, immature eggs, unfertilized eggs, abnormally fertilized eggs or follicular cells) for research or teaching purposes. Before using the blood or tissue for research or teaching, any identifying information about you will be removed.

**[n<sup>th</sup> (e.g., first, second, etc.)] CYCLE OF TREATMENT**

I have read this entire consent form and have had the chance to ask any questions I might have about my treatment. My consent to treatment is purely voluntary. I understand that my consent applies to only one treatment cycle and that I may withdraw my consent at any time. I have received a copy of this form.

**Patient:**

\_\_\_\_\_ Date: \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

**PHYSICIAN CERTIFICATION:** I hereby certify that before treatment began, and before the patient signed this document,

- (i) I or the staff at this program have provided the patient with information about the nature, purpose, benefits, risks of, and alternatives to, the proposed treatment; and
- (ii) I have met with the patient to discuss the information, have given the patient an opportunity to ask any questions, and have fully answered such questions.

I believe that the patient fully understands what I have explained and answered and has consented to undergo the proposed treatment.

**Physician Responsible for the Patient's Care:**

\_\_\_\_\_ Date: \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)