Consent for Frozen Embryo Transfer
Assisted Reproductive Technologies

We _____________________________________ and _____________________________________ agree to have Specialists in Reproductive Medicine & Surgery, P.A. (SRMS) transfer some or all of our cryopreserved embryos.

We understand that not all of the embryos will necessarily survive the freeze/thaw process. While SRMS certainly values our desires, we leave it to the sole discretion of SRMS and the Assisted Reproductive Technologies Team to determine how many of the embryos will be thawed for transfer on this cycle.

We understand that a new consent will be requested for each individual frozen embryo transfer cycle performed.

_______________________  ______________________ __/___/___  
Woman’s Signature  Woman’s Name (print)  Date

_______________________  ______________________ __/___/___  
Partner’s Signature  Partner’s Name (print)  Date

_______________________  ______________________ __/___/___  
Nurse Coordinator Signature  Nurse’s Name (print)  Date

_______________________  ______________________ __/___/___  
Practitioner’s Signature  Practitioner’s Name (print)  Date

Updated 1/22/2009
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