

Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics



Gestational Surrogacy Commissioning Couple-Intended Parent Packet Review Consent Form

I have read the provided information on the following treatment(s)/procedure(s):

- Southwest Florida Surrogacy Program General Patient Information
- Gestational Surrogacy Price List
- Gestational Surrogacy Commissioning Couple-Intended Parent Consent For Therapy
- Patient Information Summary Assisted Reproductive Technologies
- Consent For Criminal History Check
- Consent For Cryopreservation of Embryos
- FET Agreement In Gestational Surrogacy Procedures General and Monthly Consent Form
- ART Glossary of Terms

Gestational Surrogacy Commissioning Couple-Intended Parent Packet Review Consent Form (this form)

- Testing For Sexually Transmitted Diseases
- Semen Analysis & Anti-Sperm Antibody Screening Patient Information
- Lupron® & Synarel® Patient Information
- Ovarian Superovulation Injectable Medications General Information
- ASRM Fact Sheet: Side Effects of Gonadotropins
- Antibiotic Therapy During ART General Information
- Human Chorionic Gonadotropin (HCG) Patient Information
- Ovarian Hyperstimulation Precautions
- Early Pregnancy Patient Instructions

I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have read and understand the above patient information packet(s), and I have had an opportunity to ask questions regarding the above topic(s) and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medication(s) and/or the performance of particular procedure(s) and wish to proceed with the above treatment(s) and procedure(s).

Patient Name (print)

____/____/____
Date

Patient Name (signature)

____/____/____
Date

Guardian (if necessary)

____/____/____
Date

Witness

____/____/____
Date

Practitioner

____/____/____
Date