

Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics



Oocyte Cryopreservation Packet Review Consent Form

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

- Dream Discount Plus Program Flyer
 - Patient Information Summary Oocyte Cryopreservation
 - Oocyte Cryopreservation Price List
 - Dream Discount Plus Program Consent
 - Study Subject Consent for Participation in Oocyte Cryopreservation Study - 201
 - Consent For Cryopreservation of Oocytes
 - Billing Information For Transferring Client Depositors From Another Bank
 - Xytex Tissue Storage Release To Transfer For Ovarian Frozen Egg Tissue
 - Ovarian Frozen Egg Storage Agreement For Client Depositor
 - Oocyte Cryopreservation Brochure
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- Oocyte Cryopreservation Packet Consent Form (this form)
 - Lupron® & Synarel® Patient Information
 - Aromatase Inhibitors General Patient Information
 - Ovarian Superovulation Injectable Medications General Information
 - ASRM Fact Sheet: Side Effects of Gonadotropins
 - Ganirelix Acetate Injection Patient Information
 - Human Chorionic Gonadotropin (HCG) Patient Information
 - Ovarian Hyperstimulation Precautions
 - ART Glossary of Terms

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

Updated: 02/03/2016

