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**

- ❒ **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