Superovulation-IUI Packet Review Consent Form

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

- Prepayment of All Insemination Procedures Now Required
- Superovulation-IUI Price List
- Ovarian Superovulation Injectable Medications General Information
- ASRM Fact Sheet, Side Effects Of Gonadotropins
- Superovulation-IUI Packet Review Consent Form (this form)
- Urinary LH Monitoring During Ovarian Superovulation Cycles
- Human Chorionic Gonadotropin (HCG) Patient Information
- Intra-Uterine Insemination (IUI) Patient Information
- Progesterone Therapy Patient Information
- Ovarian Hyperstimulation Precautions
- Early Pregnancy Patient Instructions

I understand that SRMS is a medical practice pursuant to the rules and regulations of the Florida Board of Medicine. 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: 2/14/2010
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