40673

MR-836 (9-2017)

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR EGG DONATION
(PARTNER DONOR/RECIPROCAL IVF)

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ______________________________

DOB OR MR #: ______________________________

1. I, ________________________________, consent for the physicians and staff of the Women &
(print Partner Donor's full name)
Infants Fertility Center (WIFC) to perform oocyte (egg) retrieval on me for the purpose of donating the retrieved eggs ("donor eggs") to my partner, __________________________________ ("Partner") for
(print Partner Recipient's full name)
use during in vitro fertilization (IVF) procedures in an attempt to achieve a pregnancy.

2. Screening

I understand that WIFC follows a screening process prior to the transfer of reproductive tissue from one patient to another. I am required to complete a profile detailing my personal, medical and family history to the best of my ability. I will undergo an evaluation, including blood tests, to screen for HIV and other infectious diseases, a psychological consultation, and a history and physical examination, and any other tests the WIFC physicians deem appropriate.

3. Medications (hyperstimulation), monitoring and blood tests.

The use of "fertility drugs," such as oral contraceptive pills, GnRH-agonists, gonadotropins, GnRH-antagonists, human chorionic gonadotropin (hCG), progesterone, estradiol, letrozole, and antibiotics has been explained to me, and their respective risks and side effects have been discussed. I understand that some of these drugs may be used "off label" (not approved by the FDA for this use). I understand that some of these medications are administered by intramuscular or subcutaneous injection and may cause bruising and discomfort at the injection site.

I understand that complications may arise as a result of taking fertility drugs, which may include, but are not limited to:

- infection
- ovarian enlargement and/or hyperstimulation
- damage to the ovaries
- adverse or allergic drug reaction
- very rarely, blood clots, stroke, heart attack, and/or death

My physician has discussed with me and I understand that Ovarian Hyperstimulation Syndrome (OHSS) is a serious risk/complication of ovarian stimulation. Symptoms of OHSS include increased ovarian size, ovarian torsion (twisting of the ovary), nausea and vomiting, accumulation of fluid in the abdomen, breathing difficulties, an increased concentration of red blood cells, kidney and liver problems, and in the most severe cases, blood clots, kidney failure, or death. In severe form of OHSS, serious complications may require hospitalization and medical intervention.

I acknowledge the importance of maintaining close contact with the physicians and staff at WIFC ("IVF team") during the period of time while I receive these medications and for a minimum of two (2) weeks afterwards. While taking any of the above medications, I will be closely monitored by the IVF team

with blood tests. This monitoring may be daily and carries the risk of mild discomfort and bruising at the venipuncture (blood draw) site.

I understand that transvaginal ultrasound examinations are performed, and that there may be some discomfort with this procedure. If monitoring suggests a low probability for successful egg retrieval, my stimulation cycle may be stopped and no egg retrieval is performed. Alternatively, if my physician thinks that I am at risk for severe OHSS, the stimulation medications may be discontinued and no egg retrieval is performed.

4. Transvaginal Oocyte (Egg) Retrieval

Oocyte (egg) retrieval is the removal of eggs from the ovary. I understand that at a time determined by the IVF team, I will be admitted to Women & Infants Fertility Center as an ambulatory patient. If anesthesia is required for the egg retrieval, I will sign a separate anesthesia consent.

A transvaginal ultrasound probe is used to visualize the ovaries and the egg-containing follicles within the ovaries. A long needle, which can be seen on ultrasound, is guided into each follicle and the fluid containing the egg is aspirated (drawn up into the needle). Rarely, the ovaries are not accessible by the transvaginal route, and transabdominal retrieval is necessary.

Risks of egg retrieval include, but are not limited to:

- Infection: Bacteria normally present in the vagina may be inadvertently transferred into the abdominal cavity by the needle and may cause an infection of the uterus, fallopian tubes, ovaries or other intra-abdominal organs. Treatment of infection could require the use of oral or intravenous antibiotics. Severe infections occasionally require surgery to remove infected tissue. Infections can have a negative impact on fertility.

- Bleeding: Small amounts of blood loss are common during egg retrievals. Major bleeding may require surgical repair. The need for blood transfusion is rare; however, in very rare circumstances, unrecognized bleeding can lead to death.

- Trauma: Despite the use of ultrasound guidance, it is possible for organs or structures within the abdomen to be injured. Injury to internal organs or structures may result in the need for additional treatment, including but not limited to admission to the hospital, blood transfusion or surgery.

The exact number of eggs retrieved is not determined until their final microscopic evaluation. I understand that there is no guarantee that any eggs will be retrieved during this process.

I understand that following egg retrieval, I may experience mild abdominal discomfort and/or light vaginal bleeding. I understand that if I experience severe abdominal pain, heavy bleeding, and/or a temperature of over 100.5 degrees F, I need to contact WIFC immediately. If I am experiencing a true emergency, I understand I should call 9-1-1 or go directly to the closest emergency department.

5. Donation

I understand, intend and agree that following egg retrieval, all of the eggs retrieved shall be donated to my Partner for use in the performance of IVF.

I acknowledge that WIFC may dispose of any donor eggs that are not used by Partner.

I acknowledge my obligation to any child(ren) born as a result of my act to achieve a pregnancy with my Partner, and agree to care for, support, financially and otherwise, treat the child(ren) born as a result of these procedures, in all respects, as if my naturally conceived child(ren).

6. Discarded Material

In the hope that I may help others, I donate for teaching or research purposes any unused biological material which otherwise would be routinely discarded. I understand that no pregnancies will be generated using this material. I understand that by agreeing to this donation there is no additional risk to me. I also understand that I may refuse to donate this material and the treatment given will not be affected.

My limitations are: ____

7. General Consent Provisions

I understand that the lists of risks and complications related to the above procedures are not complete and that my physician has discussed with me that other unforeseen risks do exist and that additional procedures may be required. I consent to those procedures which my physician deems necessary.

I understand that I may require a blood transfusion as a result of the above procedures. I understand that blood transfusions are routinely done with blood donated by volunteer blood donors and that if time and my condition permits, I will be given the option to have family members donate for me. I understand there are unforeseen complications associated with a transfusion, including but not limited to transfusion transmitted diseases (HIV, AIDS), allergic reactions, chills, fever, heart, lung or kidney problems or even death. The associated risks and benefits of a blood transfusion have been discussed with me. I acknowledge that blood transfusion treatment alternatives have been discussed with me.

I acknowledge that the physicians at the Women & Infants Fertility Center are only managing infertility and that I am responsible for obtaining my general medical and gynecologic care through other physicians.

I understand that Women & Infants Hospital is a teaching hospital where fellows, residents and advanced practicing medical and nursing students may observe and/or perform IVF and its related procedures under the direct supervision of licensed practitioners of accredited teaching programs.

I consent to the taking of photographs, videotapes and/or illustrations of procedures, eggs, sperm, embryos, etc. and other medical problems for diagnostic, educational or scientific purposes, provided my identity is not revealed.

I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantee or promise has been given to me by anyone as to the results of my treatment. I understand that the above described procedures are done by the Women & Infants Fertility Center team and that my primary physician may not be the one doing them.

I understand that WIFC makes no representation, express or implied, with respect to the nature of the legal relationship of any embryos (eggs fertilized with sperm) created or any child(ren) born as a result of the use of donated eggs. I understand that I should consult with legal counsel in this regard.

I acknowledge that this form has been explained to me and I understand its contents. I have had the opportunity to ask questions which have been answered to my satisfaction.

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
Partner Donor

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by this donor.

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
(Provider)

Print Name:_______________________________
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this donor.

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
(Interpreter)

Print Name:_______________________________
(Interpreter)

40735

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

PATIENT CONSENT FOR FERTILITY TREATMENT DURING COVID-19 AT WOMEN & INFANTS FERTILITY CENTER

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ______________________

DOB OR MR #: ______________________

C19-40735 (5-2020)

COVID-19 has been declared a worldwide pandemic by the World Health Organization. Although the exact mode of transmission is not entirely known, COVID-19 is contagious and is believed to spread by person-to-person contact. Despite taking reasonable preventative measures that are aimed to prevent the spread of COVID-19, an inherent risk of becoming infected with COVID-19 by virtue of proceeding with fertility treatment still exists.

By seeking treatment at Women & Infants Fertility Center I ______________________
(Patient's Name)

(or ______________________ for ______________________)
(Legal Guardian) (Patient's Name)

and ______________________ (if applicable) acknowledge and understand:
Partner's Name

1. Despite all precautions offered to me/us or taken by my/our providers, there is no guarantee that I/we will not be exposed to and/or infected with COVID-19.
2. Use of personal protective equipment (PPE) can minimize risk but does not eliminate the risk of transmission of COVID-19.
3. Possible exposure to COVID-19 may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and/or the risk of death.
4. The impact of COVID-19 on pregnancy for both the mother and baby is not fully known. I/we acknowledge that any febrile illness in early pregnancy may increase the risk of miscarriages and birth defects and that pregnant women appear to be at greater risk of severe complications from other respiratory viral infections such as influenza.
5. Even if I/we have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus, there is a chance I/we may have contracted COVID-19 after the test and I/we acknowledge that I/we may still transmit the undetected virus to another person.
6. My/Ourtreatment/procedure may be delayed or canceled should I/we develop symptoms, be tested positive for COVID-19 or for a variety of others reasons including changing regulations and restrictions surrounding COVID-19, availability of staff, the availability of adequate PPE or other reasons. If treatment is modified or canceled this can interfere with the ability to become pregnant through treatment as well as have financial consequences including not being reimbursed for expenses already incurred.
7. I/we are expected to follow reasonable precautions set forth by the WIFC such as wearing a facemask at all times in the clinic and to observe social distancing and proper handwashing both inside and outside of the clinic during the course of treatment.
8. These precautions may also include the request to self-quarantine and to pursue any testing for patient, or partner if applicable, related to COVID-19 before treatment. I/we understand that it may be necessary to obtain this testing at an outside lab and there may be extra costs associated with this testing.
9. Failure to comply with these requests, follow recommended precautions, as well as exposure to, developing symptoms of, or testing positive for COVID 19 may result in the delay or cancelation of treatment.
10. If treatment is delayed or canceled, this can have financial consequences including not being reimbursed for expenses already incurred.

11. The staff at WIFC is providing fertility treatment and I/we are responsible for obtaining other healthcare needs through other providers including routine gynecologic and primary care, any ongoing obstetric care, and any care related to COVID-19.
12. I/we have the option to postpone fertility treatment to minimize the risk of acquiring COVID-19.

I/we have been counseled about resources available to provide further information about COVID-19. I /we have had the opportunity to read this form, or have it read to me/us, and I/we understand it. I/we have had the opportunity to ask questions and they have been answered to my/our satisfaction. Understanding all of the above, I/we desire to proceed with fertility treatments.

Time: ________ AM / PM Date: ________________ Signature: ____________________________

(Patient or Legal Guardian)

Relationship: __________________________

Time: ________ AM / PM Date: ________________ Signature: ____________________________

Partner, if applicable

Provider's Acknowledgement:

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: ________ AM / PM Date: ________________ Signature: ____________________________

(Provider)

Print Name: ___________________________

(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: ________ AM / PM Date: ________________ Signature: ____________________________

(Interpreter)

Print Name: __________________________

(Interpreter)

For Partner's Signature if not signed at WIFC

STATE OF ____________________

COUNTY OF __________________

Then personally appeared before me the above named ________________________, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of ____________________________, 20____.

NOTARY PUBLIC: ___________________________________
MY COMMISSION EXPIRES: _____________________________