CONSENT FOR IN VITRO FERTILIZATION USING A TRADITIONAL SURROGATE (INTENDED PARENTS)

1. I _____ and _____
(Print Intended Parent's name) (Print Intended Parent's name, if applicable)
collectively referred to as the "Intended Parents" have requested treatment by the physicians and staff at the Women & Infants Fertility Center (WIFC) for the purpose of creating a child. I/we consent to allow the WIFC physicians and staff ("IVF team") to perform in vitro fertilization (IVF) using a traditional surrogate for the purposes of achieving a pregnancy.

2. I/we have selected _____, as the "Traditional Surrogate" to carry
(Print Traditional Surrogate's name)
my/our child.

3. I/we understand that I/we may have conflicting interests with each other (if applicable) and with the Traditional Surrogate. I/we understand that WIFC requires all parties to seek independent legal counsel and enter into a written agreement to address all areas of agreement, concern and conflict which may arise, including but not limited to actions to be taken in the event of a multiple pregnancy of twins or more, and the parental rights of the resulting embryos and/or child(ren).

4. Definitions
   a. **Traditional Surrogate** – the person who carries the child of Intended Parent(s) and has a genetic link to the developing child(ren) through the use of the Traditional Surrogate's own eggs. After IVF is performed on the Traditional Surrogate, resulting embryos are transferred back into the Traditional Surrogate's uterus.
   b. **Embryo** – an egg fertilized by sperm.
   c. **Cryopreservation** – a preservation process through freezing.
   d. **In Vitro Fertilization** (IVF) – a process whereby egg growth is stimulated in the ovaries with the resultant eggs being retrieved and fertilized by sperm in the laboratory.
   e. **Embryo Transfer** – the placement of embryos into the uterus.

5. Screening Process

I/we understand that the oocytes (eggs) used in the IVF process are obtained from the Traditional Surrogate, and the sperm used in the IFV procedure is obtained from the Intended Parent or a sperm donor. If donor sperm is used, additional consent forms will need to be signed.

I/we are aware that WIFC follows a screening process prior to the transfer of reproductive tissue from one patient to another. I/we will have a complete evaluation and screening for infectious disease, including tests to screen for HIV, hepatitis, and other tests WIFC deems appropriate, as necessary. Other studies as indicated by medical and/or family history may also be obtained.

I/we acknowledge that WIFC will perform the same or similar screening tests on the Traditional Surrogate.

I/we understand that WIFC does not make any guarantee about the reliability of the information

provided by the Traditional Surrogate in the above-described screening process. I/we understand that WIFC is not responsible for the accuracy or reliability of information obtained from the Traditional Surrogate during the screening process.

I/we understand that WIFC cannot and does not assume any responsibility or liability for the Traditional Surrogate's actions or inactions during the screening process.

6. Embryo Transfer

I/we understand that the outcome of IVF correlates with the number and quality of embryos transferred to the Traditional Surrogate's uterus. I/we understand that there is a risk of multiple gestation (more than one baby) following IVF, and that the seriousness of the risk correlates directly with the number of embryos transferred.

The risks of multiple gestations include, but are not limited to:

- preterm labor and the delivery of premature infants that may require intensive care and may have long-term complications associated with prematurity
- pregnancy-induced diabetes
- pre-eclampsia (a dangerous elevation of blood pressure during the pregnancy)
- miscarriage

I/we acknowledge that it is WIFC's policy to limit the number of embryos transferred according to maternal age and embryo quality. The IVF team has explained that the purpose of this policy is to maximize the chance of pregnancy while reducing the rate of multiple gestations.

Embryo transfer is not performed if there are no suitable embryos. This occurs because there are no eggs retrieved from the Traditional Surrogate, the eggs do not fertilize or because the embryos do not develop normally. If the embryo transfer is not performed, I/we understand the Traditional Surrogate will not get pregnant in that cycle.

I/we are aware that there is no guarantee that a pregnancy will occur as a result of this treatment. The chances of a successful outcome have been explained to me/us by the IVF team.

I/we understand that the IVF team cannot guarantee the physical or mental health of any infant resulting from these procedures.

7. Future Genetic Screening

I/we understand that any child(ren) born as a result of these IVF procedures may be related (genetically, biologically or both) to any present or future child(ren) of the Traditional Surrogate, and that these child(ren) should have blood tests, and other appropriate genetic screening tests to determine a potential genetic relationship with a partner prior to entering into any relationship that could produce a child. I/we understand that these child(ren) should disclose to any partner the potential for genetic relationship and the importance of the partner undergoing blood tests and other appropriate genetic screening tests as well.

I/we understand that WIFC has no obligation or duty whatsoever to make any of the foregoing disclosures to any person at any time.

8. Discarded Material **(Intended Parent(s) to initial below)**

_____ Initials _____ Initials

In the hope that I/we may help others, I/we donate for teaching or research purposes any unused biological material including follicular fluid, sperm, immature and/or unfertilized eggs, abnormal and/or arrested embryos (those which have stopped developing) which otherwise would be routinely discarded. I/we understand that no new pregnancies will be generated using this material. I/we understand that by agreeing to this donation there is no additional risk to me/us. I/we also understand that I/we may refuse to donate this material and the treatment given would not be affected.

9. General Consent Provisions

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

Alternative options to IVF and the risks and benefits of these alternative options have been explained to me/us by the IVF team, including procedures that are not performed here, and other non-medical options such as adoption or non-treatment, and I/we understand them.

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

I/we 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/we 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/our identity is not revealed.

I/we agree to notify the Women & Infants Fertility Center of the birth of any child(ren) as a result of IVF procedures.

I/we are aware that the practice of medicine is not an exact science. I/we acknowledge that no guarantee or promise has been given to me/us by anyone as to the results of my/our treatment. I/we understand that monitoring, egg retrieval, and embryo transfer will be done by the Women & Infants Fertility Center team and that my/our primary physician may not be the one doing this.

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 #: _____

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

Time: _____ A.M./P.M. Date: _____ Signature: _____
Intended Parent

Time: _____ A.M./P.M. Date: _____ Signature: _____
Intended Parent

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by the Intended Parent(s).

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 the Intended Parent(s)

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: _____