40649

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR THERAPEUTIC USE OF DIRECTED DONOR SPERM -SUBSEQUENT USE

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 _____ and _____ are treating at
(print patient's full name) (print partner's full name, if applicable)

the Women & Infants Fertility Center (WIFC) for the purpose of achieving a pregnancy.

I/we have considered the available options for achieving parenthood, including procedures that are not performed at WIFC, and other non-medical options such as adoption or non-treatment, and have chosen to attempt pregnancy using the sperm of a directed (known) donor.

I/we understand that there are many steps involved in the use of directed donor sperm, including cryopreservation of the directed donor's sperm samples, adequate quarantine of these sperm samples (as directed by the regulatory agencies), approval by the clinical and psychological staff of WIFC, proper completion of the informed consent process and using the sperm for intrauterine insemination (IUI) or in vitro fertilization (IVF).

I/we understand that there is no guarantee that pregnancy will occur using sperm from a directed donor.

I/we also understand that there are potential risks associated with this procedure, including the possibility that infection could be introduced into the patient.

I/we understand that in some cases, the birth of a child by use of known donor sperm can produce psychological problems for me/us, my/our family, the donor, the donor's family, or the child(ren).

I/we understand that the directed donor sperm sample(s) must be frozen by a sperm bank outside of WIFC that is registered with the Food and Drug Administration (FDA) and I/we understand that WIFC will not use the donor sperm if the sample does not meet these requirements.

I/we understand that I/we are responsible for having the sperm sample(s) delivered to WIFC's Andrology Laboratory prior to the treatment cycle.

I/we understand that the same types of complications can arise during pregnancy and delivery of a child conceived with use of donor sperm as a child conceived by sexual intercourse or fertility treatment using the partner's sperm. It is also possible that the resulting child(ren) could be born with abnormalities, abnormal traits, disabilities or hereditary tendencies from either biological parent, as could a child conceived by sexual intercourse.

I/we accept this act as my/our own, and acknowledge my/our obligation to the child(ren), and agree to care for, support and otherwise treat the child(ren) born as a result of this procedure, in all respects, as if my/our naturally conceived child(ren).

I/we understand that I/we may be contacted for a follow-up consultation by WIFC.

I/we understand that federal regulations and reporting requirements obligate WIFC to provide the Centers for Disease Control with cycle-specific data regarding the treatment cycle and the pregnancy outcome. However, I/we understand that any and all personal identifiers associated with this treatment will be protected under the Privacy Act. Information obtained and identified with me/us during this procedure will remain confidential and will not be disclosed, except to authorized employees of the Rhode Island State Department of Health or other government agencies with my/our permission.

I/we acknowledge that this form has been explained to me/us 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: _____
Patient

Time: _____ A.M./P.M. Date: _____ Signature: _____
Partner, if applicable

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by this patient (and partner, if applicable).

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 patient (and partner, if applicable).

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: _____