40181

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

INFORMED CONSENT FOR INSEMINATION WITH PARTNER'S SEMEN

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 #: _____

MR-219 (5-2020)

1. _____ and _____
(Patient's Name) (Partner's Name)

understanding the options and alternatives, authorize Women & Infants Fertility Center (WIFC) to inseminate Patient one or more times with Partner's semen, with or without fertility medications, in attempt to achieve pregnancy. I/we voluntarily consent to the insemination procedures as set forth below. I/we understand that the insemination(s) may take place during multiple menstrual cycles during this treatment and that this consent is valid for 1 (one) year from the date of signature. I/we understand that at any point in the year any signing party may revoke consent by certified letter to WIFC.

2. I/we understand that the semen to be used for insemination(s) may be fresh or frozen. I/we understand, acknowledge, and agree that preconception testing such as for infections and inheritable conditions have been offered to Patient and Partner as well as the opportunity to discuss these results prior to pursuing treatment. I/we understand that, regardless of any testing performed, there is still a small risk of transmission with infectious diseases or other undesirable outcomes via insemination.

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

4. I/we understand that alternative options to this procedure exist and the risks and benefits of these alternative options have been explained, including procedures that are not performed at WIFC, and other non-medical options such as adoption or non-treatment, and I/we understand them.

5. I/we understand that risks exist with insemination, including but not limited to:

- infection;
- multiple pregnancy (especially if fertility drugs are used)

6. I/we understand that pregnancies resulting from this procedure are subject to the same risks and complications as pregnancies achieved without medical intervention, including but not limited to:

- ectopic pregnancy (pregnancy occurring outside of the uterus and is life threatening)
- preterm labor
- pregnancy with birth defects
- miscarriage
- stillbirth

7. I/we acknowledge that the WIFC cannot guarantee the health of any infant resulting from this procedure.

8. I/we understand that there is no guarantee that a pregnancy will occur as a result of this treatment. Our physician has discussed the chances of a successful outcome.

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

10. 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 this treatment. I/we understand that the above procedures are done by the Women & Infants Fertility Center team and that my/our primary physician may not be the one doing them.

11. 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: _____AM/PM Date: _____ Signature: _____
(Patient)

Time: _____AM/PM Date: _____ Signature: _____
(Partner)

Provider's Acknowledgement
I confirm that consent, as described above, has been given by this patient and partner.

Time: _____AM/PM Date: _____ Signature: _____
(Provider)
Print Name:_____

Interpreter's Acknowledgement (if applicable):

Time: _____AM/PM Date: _____ Signature: _____
(Provider)
Print Name:_____

<u>For Partner's Consent if not signed at WIFC</u>

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: _____

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: _____