WAKE FOREST BAPTIST HEALTH
CENTER FOR REPRODUCTIVE MEDICINE

CONSENT TO TRANSFER OF CYROPRESERVED EMBRYOS

I (female patient) _____ and partner (if applicable) _____, patient(s) at the Wake Forest Baptist Health Center for Reproductive Medicine (hereafter referred to as Center) hereby consent as follows:

1. I have decided to proceed with transfer of my frozen embryo(s). Accordingly, I consent to the receipt of thawed cryopreserved embryo(s) for the purpose of transfer into my uterine cavity to attempt to achieve pregnancy.

2. I understand that there are four major steps in this process:

   (i) Hormone replacement therapy to prepare the lining of the uterus for implantation

   (ii) Thawing of cryopreserved embryo(s)

   (iii) Assisted Hatching (AH) of the embryo(s)

   (iv) Transfer of embryo(s) to the uterine cavity

3. I understand that there are risks involved in all these procedures. The hormone replacement therapy (consisting of estrogen and progesterone) may cause headaches, irritability, nausea, and mood swings. In high doses, estrogen has been associated with high blood pressure and blood clotting leading to stroke and heart attack. The risks associated with thawing cryopreserved embryo(s), Assisted Hatching, and transfer of the embryo(s) to the uterine cavity have been discussed with me in connection with my consent to participate in the in vitro fertilization (IVF) program.

4. I understand that I will be responsible for the costs of thawing the embryo(s), preparing the embryo(s) for transfer, and for transferring the embryo(s) into my uterine cavity. I acknowledge that my insurance may not reimburse me for this procedure.

5. I acknowledge that any questions I had about the Center or receiving frozen embryo(s) have been answered to my satisfaction by the staff.

6. An executed copy of this form has been provided to me for my records.

X _____ _____
Patient Signature Date

_____ _____
Patient Name Date of Birth

X _____ _____
Spouse / Partner Signature Date

_____ _____
Spouse / Partner Name Date of Birth

**** NOTARIZATION REQUIRED IF DOCUMENT IS NOT SIGNED BY ALL PARTIES IN THE PRESENCE OF CLINIC STAFF****
Notary Public
Sworn and subscribed before me on this _____ day of _____, _____.

X _____ _____

FET consent revised 4/20/18