Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

Embryo Donation Recipient Frozen Embryo Transfer Packet Review Consent Form

I have read the provided information on the following treatment(s)/procedure(s):

General Information

- ❒ **Embryo Donation Recipient Frozen Embryo Transfer Packet Review Consent Form (this form)**
- ❒ **Recipient General Consent for Donated Embryos**
- ❒ **Embryo Donation Recipient General Information**
- ❒ **Frozen Donor Embryo Transfer Price List**
- ❒ **Monthly Consent for Frozen Donor Embryo Transfer**
- ❒ **Notification of Genetic Concerns by Embryo Donation Recipients**
- ❒ **ART Glossary of Terms**

Ovulatory Patents

- ❒ **Natural Cycle Frozen Embryo Transfer Patient Instructions**
- ❒ **Urinary LH Monitoring During Frozen Embryo Transfer Cycles**
- ❒ **Antibiotic Therapy During ART General Information**
- ❒ **Progesterone Therapy Patient Information**
- ❒ **Corticosteroid Therapy General Information**

Anovulatory Patents

- ❒ **Frozen Embryo Transfer (FET) Replacement Cycle Protocol Patient Instructions**
- ❒ **Lupron® & Synarel® Patient Information**
- ❒ **Estrogen Patient Information**
- ❒ **Antibiotic Therapy During ART General Information**
- ❒ **Progesterone Therapy Patient Information**
- ❒ **Corticosteroid Therapy General Information**

I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have read and understand the above patient information packet(s), and I have had an opportunity to ask questions regarding the above topic(s) and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medication(s) and/or the performance of particular procedure(s) and wish to proceed with the above treatment(s) and procedure(s).

_____	___/___/___	_____	___/___/___
Patient Name (print)	Date	Patient Name (signature)	Date
_____	___/___/___	_____	___/___/___
Guardian (if necessary)	Date	Witness	Date
_____	___/___/___		
Practitioner	Date		

Updated: 2/7/2010

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