Consent Name: QFG Consent for Assisted Reproductive Treatment

Name Partner 1 _____ Date of Birth ___/___/___

Address: _____

Name Partner 2_____ Date of Birth ___/___/___
(if applicable)
Address:_____

or

VPS patient or Couple label

1 I, as an individual, or we, as a couple in an ongoing relationship, request Queensland Fertility Group (QFG) provide us with treatment using assisted reproductive technology, including in vitro fertilisation (IVF).

2 I/we have had the nature of this treatment explained to us by the treating clinician listed below and have had the opportunity to ask questions which have been answered to our satisfaction

3 I/ We have read the QFG Pathway of Patient Care booklet which includes information on IVF, ET, embryo freezing and transvaginal ultrasound scans and have had our questions answered to our satisfaction.

4 I/we understand that I/we may withdraw or vary consent at any time

5 I/we consent to the procedures of:

(a) Controlled ovarian stimulation
(b) Transvaginal ultrasound scans
(c) Egg collection by the transvaginal or abdominal route
(d) In Vitro Fertilisation, referred to as (IVF) hereafter
(e) Intra-Cytoplasmic Sperm Injection (ICSI) if applicable
(f) Embryo Transfer into the uterus referred to as (ET) hereafter
(g) Surgical recovery of sperm from the testis, is required additional consent required

6 I/we understand that assisted reproduction is not always successful and that no guarantees can be given that pregnancy will occur. I/we have had the following explained to us:

(a) The cycle may be cancelled or discontinued due to poor response (no follicular development) or excessive response (high follicle numbers). Premature ovulation of some or all your follicles (release of eggs prior to the egg pick up procedure) may also lead to cancellation. I/we understand that cancellation fees will apply
(b) Sometimes no eggs will be retrieved at the time of the egg pick up / collection procedure
(c) Sometimes no fertilisation of eggs may occur and therefore there is no embryo to replace at transfer. Since they cannot assist in pregnancy achievement, these unfertilised eggs will be discarded
(d) Sometimes despite successful fertilisation, the embryos fail to develop normally or stop development, and as such there will be no suitable embryos for transfer and/or freezing, these embryos will be discarded
(e) If no semen sample is provided on the day of egg pick up procedure, freezing eggs may be an option. Additional costs will be incurred for this service. Verbal consent will be sought after discussions between all parties and the treating clinician

7. If the semen sample on the day of egg pick up is not of a quality that is suitable for IVF treatment, *ICSI (intra-cytoplasmic sperm injection)* may be required.

8. We agree to pay all fees levied by QFG on the dates indicated by the QFG team. We acknowledge we have received informed financial consent appropriate to the nature of our treatment.

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VPS patient or Couple label

9 I/we understand that treatment with assisted reproduction and the related procedures has complications, including but not limited to the following:

(a) Ovarian hyperstimulation syndrome, this occurs when there is an over response of the ovaries to the stimulation medications. This may occur in up to 5% of cycles. The risks associated with ovarian hyperstimulation may include pain, nausea, breathlessness, abdominal swelling and fluid retention. In severe cases of OHSS hospitalisation may be required

(b) I/we are aware the egg pick up procedure has risks including pelvic infection, which can sometimes become a serious infection with formation of pelvic abscesses

(c) Although rare, there is a risk of organ injury with resultant damage to the ovaries, the bladder, bowel or other internal organs

(d) Excessive vaginal or pelvic bleeding may occur in rare cases, there may be a need for a blood transfusion and exploratory abdominal or other surgery

(e) If undergoing a general anaesthetic, complications may arise. These will be discussed with a Specialist anaesthetist at a pre-operative assessment prior to the egg pick procedure

(f) Adverse reaction may occur to prescribed medication and medication side-effects as described in the individual consumer medicine information supplied with all medications prescribed

(g) QFG has policies in place which limit the number of embryos permitted to be transferred in any fresh embryo transfer

(i) Only one embryo can be transferred in women under 38 years of age in the first two cycles

(ii) Patients aged 38 years and above, after consultation with your treating fertility specialist to discuss implications, may have a maximum of two embryos transferred in any fresh embryo transfer

(iii) Multiple pregnancy rates from a single embryo transfer is under 5%. The more embryos replaced in any one transfer the greater the risk of a multiple pregnancy with its associated risks and complications to both mother and baby

(iv) I/we are aware that the Doctor may convert a planned fresh embryo transfer cycle to a freeze all cycle if it is clinically indicated and therefore no fresh transfer will take place

ICSI consent

After reading the QFG Pathway of Patient Care booklet and specifically the information on Intra-cytoplasmic Sperm Injection (ICSI);

(a) I/We authorise QFG to proceed with fertilisation using ICSI.

(b) I/We have discussed this with our treating clinician and have no objection and authorise for this procedure to being undertaken.

(c) I/We understand there will be non refundable fees associated with this procedure request that are not refundable should failed fertilisation occur.

(d) I/We understand this procedure does not guarantee a successful outcome.

Full name: _____ Signature: _____ Date: / /
(Partner 1)

Full name: _____ Signature: _____ Date: / /
(Partner 2; if applicable)

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Address: _____

or

VPS patient or Couple label

Embryo transfer consent

I/We have read the QFG Pathway of Patient Care booklet including how many embryos should be transferred and understand only **one embryo will be transferred** unless a 2 is placed in the box and countersigned by your fertility specialist.

☐ _____
Signature of treating Fertility Specialist

Full name: _____ Signature: _____ Date: / /
(Partner 1)

Full name: _____ Signature: _____ Date: / /
(Partner 2; if applicable)

Freezing or storage of embryos consent

I/We hereby authorise QFG to freeze any embryos, which are suitable for freezing for storage and subsequent treatment. Your signature authorises the freeze of suitable embryos unless this consent is withdrawn prior to the time of Embryo freezing.

I/We understand that not all embryos may be suitable for freezing and that there are, sometimes no embryos available to freeze.

I/We understand that, despite careful freezing and later thawing, the embryos may not survive the freeze-thaw process and may not be recovered during the thaw process.

I/We understand there will be fees associated with ongoing storage of embryos, I/We have been provided with informed financial consent as to the current ongoing cost.

Full name: _____ Signature: _____ Date: / /
(Partner 1)

Full name: _____ Signature: _____ Date: / /
(Partner 2; if applicable)

I/We understand that at times there are frozen embryos which have been created and frozen which are in excess to my/our needs. I/We understand in this circumstance that the following options are available:

(a) Allowing the storage of the embryos to be discontinued, the embryos will be removed from storage and will remain at room temperature until they are no longer viable, thereby unable to achieve a pregnancy.
(b) Donating the embryos to another infertile couple through QFG.

In acknowledging the above, I/we understand that any future decisions on the fate of excess embryos in storage will require further written consent to confirm my/our decisions with respect to the stored embryos.

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I/We understand that embryos can be frozen and stored with QFG for a period of 10 years from the date of storage. After this time if QFG are unable to contact you to provide further direction or consent to the ongoing storage the embryos will be removed from storage and disposed.

I/We understand that in the event storage fees remain unpaid for a period of 2 years and QFG is unable to contact me/us via the contact details provided to QFG, the embryos will be removed from storage and disposed.

I/We understand that in the event of the death of either partner embryo(s) can only be disposed of or used by my partner for the intention of achieving a pregnancy. Embryos are unable to be donated posthumously.

Posthumous consent

In the event of my death, it is my wish that my gametes and / or our embryo(s) be:

☐ Made available for use by my partner (if applicable), if they wish.

☐ Removed from storage and disposed.

Full name: _____Signature: _____Date: / /
(Partner 1)

In the event of my death, it is my wish that my gametes and / or our embryo(s) be:

☐ Made available for use by my partner, if they wish.

☐ Removed from storage and disposed.

Full name: _____Signature: _____Date: / /
(Partner 2; if applicable)

Genetic testing to investigate common genes that could affect the health of our children.

I/We understand that any individual could be a carrier of common gene variants, such as cystic fibrosis or spinal muscular atrophy that could cause a serious health problem in my/our children.

I/We understand that QFG advises that I/we should consider being tested for common variant genes of this sort. I/We have been provided written and/or electronic material about preconception genetic screening.

I/We understand that it is my/our decision to have further genetic testing carried out and have been provided with detailed information about this testing to assist us in my/our decision making.

Full name: _____Signature: _____Date: / /
(Partner 1)

Full name: _____Signature: _____Date: / /
(Partner 2; if applicable)

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Name Partner 1 _____ Date of Birth ___/___/___

Address: _____

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(if applicable)
Address: _____

or

VPS patient or Couple label

Use of gametes and embryos for testing, training, and quality assurance purposes.

I/We understand that training and quality assurance is an important part of the activities of QFG and that medical, nursing, or scientific staff with different qualifications might be involved in the treatment procedure. However, when any training activities are conducted, a member of the clinical or scientific team will be supervised by more experienced staff when undertaking a procedure.

If there are gametes (eggs or sperm) not suitable for insemination or that do not fertilise, we request that they be **(please tick only one option):**

☐ Made available for training, testing, or quality assurance purposes.
OR
☐ Disposed of in accordance with QFG procedures.

If there are embryos not suitable for clinical use (transfer or freezing), we request that they be **(please tick only one option):**

☐ Made available for training, testing, or quality assurance purposes.
OR
☐ Disposed of in accordance with QFG procedures.

Full name: _____Signature: _____Date: / /
(Partner 1)

Full name: _____Signature: _____Date: / /
(Partner 2; if applicable)

Use of personal health information

I/We understand QFG is bound by the requirements of the Privacy Act 1988 with respect to the management of sensitive patient health information and I/we may request a copy of the QFG Privacy Policy at any time.

I/We have read and signed the Privacy policy for QFG (this is signed at initial Nurse Interview and scanned to your patient file).

I/We understand that care is provided by a multidisciplinary team, and that all staff members of QFG and our associated clinicians and their support teams will have access to my/our health records as required.

I/We understand that QFG is required to provide statistical data and treatment validation to meet licensing and regulatory requirements under the Fertility Society of Australia's Reproductive Treatment Accreditation Committee (RTAC) scheme for accreditation purposes. As part of that process we may be requested to make records available to independent audit teams, who are subject to strict confidentiality constraints. I/We give permission for our records to be used for these purposes.

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(if applicable)
Address: _____

or

VPS patient or Couple label

I/We give permission for QFG to use my/our personal health information for research and quality assurance purposes. I/We understand that no information will be provided to third parties without first being fully de-identified.

Change of circumstances and withdrawal of consent

I/We understand that it is my/our responsibility to ensure that the personal information provided to QFG is correct. I/We agree to ensure QFG will be notified in person, in writing and / or with supporting documents (as requested) of any significant change in our circumstances including but not limited to below:

(a) Change of contact details,
(b) Any change in relationship status (separation or divorce),
(c) In the event of death of either party consenting to this treatment,
(d) Withdrawal of consent to treatment.

I/We acknowledge that the nature of this treatment has been explained to me/us by our treating doctor listed below and have had the opportunity to ask questions which have been answered to my/our satisfaction.

Full name: _____ Signature: _____ Date: / /
(Partner 1)

Full name: _____ Signature: _____ Date: / /
(Partner 2; if applicable)

Treating Clinician consent

I certify that to my knowledge the above-mentioned patients have received all relevant information and counselling requirements for the provision of ART treatment at QFG.

_____ Date: / /
Signature of treating Fertility Specialist (Clinician)

PLEASE NOTE AN ADDITIONAL CONSENT IS REQUIRED IF USING DONOR SPERM TO FERTILISE THE EGGS, OR IF PGT IS REQUIRED

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