Consent Name: **QFG Consent for Frozen Embryo Transfer**

Originating Department **QLD-QFG-PM-CNT**

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 that The Queensland Fertility Group (QFG) provide us with treatment using a Frozen Embryo Transfer.

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

3 I/we understand that we may withdraw or vary consent at any time up to time of transfer.

4 I/we consent to the procedures of:
(a) Artificial thaw, requiring medication if required
(b) Transvaginal ultrasound scans, if required
(c) Embryo Transfer (ET) into the uterus of a thawed embryo/s

5 I/we understand that assisted reproduction is not always successful and that no guarantee can be given that pregnancy will occur. We have had the following explained to myself/us:
(a) The cycle may be cancelled or discontinued under the care of your treating clinician
(b) I/we understand that cancellation fees will apply
(c) I/we understand that, despite careful freezing and later thawing, the embryos may not be recovered or may not survive the freeze-thaw process and as such these embryos will be discarded
(d) I/we understand that the laboratory staff will continue to thaw further embryos until the number requested for transfer has been achieved or no embryos remain to thaw

6 We understand that treatment with assisted reproduction and the related procedures has complications, including but not limited to the following:
(a) Adverse reaction to prescribed medication and medication side-effects as described in the individual consumer medicine information supplied with all medications prescribed.
(a) 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

7 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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Address: _____

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Address:_____

or

VPS patient or Couple label

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 for women over 38 years of age a 2 is placed in the box below 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)

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

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.

We understand that QFG advises that 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.

We understand that it is my/our decision whether 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.

Use of personal health information

I/We understand QFG is bound by the requirements of the Privacy Act 1988 with the management of sensitive patient health information and we may request a copy of the Queensland Fertility Group 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 QFG 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.

I/We give permission for QFG to use 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.

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Address: _____

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

or

VPS patient or Couple label

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 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)

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