CONSENT FORM FOR TRANSFER OF EMBRYOS DIAGNOSED AS MOSAIC

Please Print

PATIENT Name: _____

Patient DOB: _____

Patient eIVF number: _____

PARTNER Name (if applicable): _____

Partner DOB: _____

Partner eIVF number: _____

Please read the following consent carefully. If you do not understand the information provided, please speak with your treating physician or nurse.

Patient and Partner (if applicable) must present PHOTO ID(s) and sign in the presence of an authorized Boston IVF staff member.

This consent must be signed by both Patient and Partner (if applicable).

If you and/or your partner are unable to sign the consent in the presence of an authorized Boston IVF staff member, the consent must be notarized using the Notarization Form attached to this consent and returned to your treatment clinic.

In vitro fertilization (IVF) treatment followed by embryo biopsy provides the opportunity to perform genetic testing on the embryo before transfer into the uterine cavity.

Preimplantation Genetic Testing for Aneuploidy (PGT-A), previously known as Preimplantation Genetic Screening (PGS), involves the testing of the embryo for the number of chromosomes and/or to determine the sex of the embryo.

Your embryos have undergone genetic testing and some of these embryos are mosaic. This means that the embryo possesses cells with both normal and abnormal chromosomal make up. The embryos diagnosed as mosaic have a significantly reduced rate of implantation and carry a significantly increased risk of miscarriage if they implant.

Mosaic embryos are classified as having low level mosaicism (mostly normal cells with few abnormal cells) or high level mosaicism (normal cells with a higher fraction of abnormal cells) and there is data indicating that some low-level mosaic embryos will implant and result in a normal live birth. However, there is the possibility that transfer of a low-level

mosaic embryo may result in a live birth with persistence of abnormal cells, which may result in physical and/or cognitive abnormalities in the child with varying degrees of severity.

In the event that we (I) request transfer of a mosaic embryo or embryos, we (I) do so understanding the following:

1. It is Boston IVF's policy to recommend another cycle of IVF with aneuploidy testing to increase the chance of identifying a normal euploid embryo (NOT mosaic) for transfer. Neither Boston IVF nor any of Boston IVF's medical professionals encourage transfer of embryos that are not "euploid" or "normal"

2. That Boston IVF's policy is to require additional genetic counselling if the only embryos available for transfer are mosaic and this counselling must be done prior to us (me) proceeding with an embryo transfer.

3. We (I) are requesting transfer of an embryo that is mosaic and that the transfer of an embryo diagnosed as mosaic is done entirely at our (my) own discretion with a full understanding of the significant risks involved.

4. In the event of an ongoing pregnancy after transfer of the mosaic embryo, we (I) understand that Boston IVF recommends retesting the developing fetus for aneuploidy via amniocentesis. We (I) understand that while no prenatal test detects all birth defects, the testing of cells in amniotic fluid is more likely to be a true representation of the fetal chromosomes. Non-invasive prenatal testing and chorionic villus sampling test placental cells and may not give a true representation of fetal chromosomes.

By signing this document, we (I) acknowledge that we (I) have read this consent, had a thorough discussion with our (my) Boston IVF physician and all of our (my) questions and concerns regarding transfer of a mosaic embryo have been fully answered to our (my) satisfaction. This discussion has included the aforementioned risks and potential complications of transferring a mosaic embryo.

We (I) acknowledge that the discussion with our (my) Boston IVF physician and caregivers was in a language that we (I) understand and we (I) were (was) provided sufficient information to allow us (me) to make an informed decision whether or not to proceed with this treatment.

We (I) understand that Boston IVF is not responsible for any birth defects, chromosomal abnormalities, false positive findings, or false negative findings arising out of our (my) decision to transfer an embryo diagnosed as mosaic. We (I) understand we (I) have been fully advised by Boston IVF of the risks of transferring a mosaic embryo and we (I) fully agree to accept any and all such risk.

Patient signature	**Partner signature (if applicable)**
Witness signature	**Witness signature**
Witness – print name and title	**Witness – print name and title**

PHYSICIAN ATTESTATION

The above mentioned patient and partner (if applicable) have been informed and counseled by me and other team members regarding the risks and benefits of the relevant treatment options, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion.

Physician Signature: _____

Date: _____/_____/_____

IDENTIFICATION DETAILS

Patient - Type of Picture Identification

Driver's License # _____ **Expiration Date:_____/_____/_____**

Passport #: _____ **Expiration Date:_____/_____/_____**

Other: _____ **Date:_____/_____/_____**

Picture Identification(s) Confirmed on Date: _____/_____/_____

Partner (if applicable) - Type of Picture Identification

Driver's License # _____ **Expiration Date:_____/_____/_____**

Passport #: _____ **Expiration Date:_____/_____/_____**

Other: _____ **Date:_____/_____/**
_____

Picture Identification(s) Confirmed on Date: _____/_____/_____

Notarization Form

This section must be completed for consents signed outside the Practice

Patient name (please print): _____

State of _____

County of _____

On this____day of_____, 20 _, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the proceeding or attached document in my presence.

_____ _____

Dated Notary Signature and Stamp

_____

Title

My appointment expires:_____

Partner name (please print if applicable): _____

State of _____

County of _____

On this____day of_____, 20 _, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the proceeding or attached document in my presence.

_____ _____

Dated Notary Signature and Stamp

_____

Title

My appointment expires:_____

Review and Revision History

Revision Number	Authorized Signature(s)	Date	Description of change (If no changes, write N/A)
0	Kim Thornton	3/18/2019	Initial version