BOSTONIVF

CONSENT TO THAW AND REFREEZE FROZEN EMBRYOS FOR GENETIC TESTING

Patient Name (please print)

Patient Date of Birth (MM/DD/YYYY) **Patient EMR number**

Partner Name (if applicable, please print)

Partner Date of Birth (MM/DD/YYYY) **Partner EMR number**

This consent serves as an addendum to the previously signed consent forms entitled "**Consent form for embryo biopsy with preimplantation genetic testing-aneuploidy" and/or** "**Consent form for embryo biopsy with preimplantation genetic testing-for disease causing genetic mutations or chromosomal structural rearrangements."**

Please initial both sections below as an acknowledgement of your understanding of each statement and consent to the indicated elements of treatment.

Patient Initial	Partner Initial	
_____	_____	**PERMISSION TO THAW, BIOPSY, & REFREEZE (TBR)** I/We hereby give our (my) permission to Boston IVF to thaw my/our frozen embryos, perform a biopsy on all embryos suitable for genetic testing and then refreeze the embryos while waiting for genetic test results. I/We understand that once frozen, the risks and benefits are the same as those discussed under our fresh IVF-related procedures, including but not limited to, that all cryopreserved embryos will incur a charge in accordance with the Fees for Embryo Cryopreservation and Storage policy of Boston IVF.
_____	_____	**RISK OF PROCEDURES** I/We have been fully advised of the risks and benefits of thawing, biopsy, and refreezing cryopreserved embryos. I/we have conferred with my/our physician and medical team and discussed that there are risks associated with the procedure. I/We understand that there is no guarantee of successful thaw, biopsy of thawed embryos, or chromosomal suitability. I/We understand that not every embryo that is thawed is suitable for biopsy. Accordingly, I/we understand that during this process the embryos may not survive the thawing process, may not be suitable for biopsy, or could be diagnosed as being genetically abnormal and disposition will be handled in accordance with our signed PGT-A and/or PGT-M/SR consents. I/We understand that to date, there are no known effects from long-term storage of cryopreserved (frozen) embryos. Although there are theoretical risks of congenital malformations, I/we understand that the best available research suggests that the rate of birth defects in children born following the cryopreservation of embryos is the same as the rate observed in an age-matched group of pregnant women who conceived without assisted reproduction.

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This consent must be signed in front of a Boston IVF witness (or as a default, an official Notary) and is valid for 120 days prior to the date of the thaw.

I/We have read the IVF Treatment Guide in its entirety and have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction to thaw, biopsy and refreeze my/our embryos as stated.

Patient Name (print) **Patient Signature** **Today's Date (**MM/DD/YYYY)

Date of Birth (MM/DD/YYYY)

PATIENT- TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:_____ State/Country:_____ Expiration Date:_____ (MM/DD/YYYY)

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

Partner Name (if applicable, print) **Partner Signature** **Today's Date** (MM/DD/YYYY)

Date of Birth (MM/DD/YYYY)

PARTNER - TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:_____ State/Country:_____ Expiration Date:_____ Date (MM/DD/YYYY)

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 Name (print) **Physician signature**

Today's Date (MM/DD/YYYY)

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Notarization Form (This form is only needed if not able to have witnessed at Boston IVF)

Patient Name (print)	Patient Signature	Today's Date (MM/DD/YYYY)
_____	_____	____/____/____

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.

ID NUMBER:_____ Expiration Date:____/____/____
(MM/DD/YYYY)

____/____/____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title
My appointment expires: ____/____/____
(MM/DD/YYYY)

Partner Name (if applicable, print)	Partner Signature	Today's Date (MM/DD/YYYY)
_____	_____	____/____/____

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.

ID NUMBER:_____ Expiration Date:____/____/____
(MM/DD/YYYY)

____/____/____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title
My appointment expires: ____/____/____
(MM/DD/YYYY)

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Review and Revision History

Revision Number	Authorized Signature(s)	Date	Description of change (If no changes, write N/A)
0	Steven Bayer	5/3/16	Initial version with revision number
1	Steven Bayer	8/31/16	Changed wording
2	Steven Bayer	11/16/17	Changed wording
3	Steven Bayer	6/8/18	Added PGT consents and new closing statement
4	Steven Bayer	9/16/19	Updated sig and notary pages
5	Sandy Li	7/15/24	Added language to conform with PGT-A updates and routine cryo consents