Disposition Consent for Embryos Reported as Whole Chromosome Aneuploid on PGT-A

Patient First and Last Name: _____
Patient Date of Birth (Month/Day/Year): _____
Partner First and Last Name (if applicable): _____
Partner Date of Birth (Month/Day/Year): _____

CYCLE NUMBER: _____

I/We, _____ (Patient), _____ (Partner, if applicable) have previously agreed that Boston IVF may identify, analyze, freeze, and/or store embryo(s) on my/our behalf for future use. **This consent describes my/our decision to 1) keep or 2) discard reported as whole chromosome aneuploid on preimplantation genetic testing for aneuploidy (PGT-A).** Embryos testing negative for aneuploidy (including mosaics), those with no result, and all embryos positive for segmental aneuploidy will remain frozen for potential future use.

I/We acknowledge this disposition consent requires the signature of all individuals who signed the original embryo freezing consent. I/We understand that if I/we inherited these frozen materials for my/our own use or obtained the frozen material(s) for use from a directed/identified donor, copies of the relevant agreements and/or consents must be provided along with this consent.

Please acknowledge the following by initialing each line:

____ ____**Whole Chromosome Aneuploid:** I/We understand, agree and acknowledge that frozen embryo(s) with whole chromosome aneuploid results have a very low chance of resulting in a full-term pregnancy. In some cases, transfer of certain whole chromosome aneuploid embryo(s) may result in the birth of a child with a chromosomal condition such as Turner syndrome, Down syndrome or Klinefelter syndrome. I/We also understand that Boston IVF will **not** transfer embryo(s) that have tested positive for whole chromosome aneuploidy. I/We also understand there are transport fees involved with the relocation of any frozen embryo(s) to a different clinic and that I/we are responsible for any expenses incurred.

____ ____**Keep Frozen:** I/We understand, agree and consent that when "KEEP FROZEN" is chosen, the frozen embryo(s) will remain in frozen storage. These embryo(s) will be subject to Boston IVF applicable storage fees and non-payment policies.

____ ____ **Discard:** I/We understand, agree and consent that when "DISCARD" is chosen, the frozen embryo(s) will be thawed and disposed of according to established medical and ethical guidelines. This material may be used for quality control purposes before being discarded in accordance with normal laboratory procedures and applicable laws. None of this material will be utilized to establish a pregnancy or a cell line.

INSTRUCTIONS FOR COMPLETING DECISION TABLE: Decisions below are based on PGT-A results, as they have been reported to Boston IVF. If you have any questions or uncertainties about results or PGT-A lab reporting policies, you must speak with your care team before signing this disposition consent. By signing this consent, you confirm that you have received information on the whole chromosome aneuploid results to your satisfaction and are ready to proceed immediately with the chosen disposition decision below. Patient must select a disposition choice and sign below. Partner (if applicable) must indicate their agreement with the chosen disposition by signing below. By doing so, you understand that the disposition choice will be acted on for all embryo(s) having a whole chromosome aneuploid result from the cycle number indicated at the top of this consent form.

PGT-A Result	KEEP FROZEN	DISCARD
Whole Chromosome Aneuploid (most will not result in full term pregnancy, in some cases may result in birth of a child with a chromosome condition such as Turner syndrome, Down syndrome or Klinefelter syndrome)		

I/We hereby acknowledge that upon receipt of our consent form, Boston IVF will immediately process the options selected.

_____ _____

Patient's Signature Date

_____ _____

Partner's Signature (if applicable) Date