

## CONSENT FORM FOR EMBRYO BIOPSY WITH PREIMPLANTATION GENETIC TESTING FOR ANEUPLOIDY

In vitro fertilization (IVF) treatment followed by embryo biopsy provides the opportunity to perform genetic testing on the embryo before it is transferred into the uterine cavity. **Preimplantation Genetic Testing for Aneuploidy (PGT-A)** involves the testing of the embryo for the number of chromosomes and/or to determine the sex of the embryo.

This consent form supplements the consent form entitled “**Consent for In Vitro Fertilization, Intracytoplasmic Sperm Injection Embryo Cryopreservation/Disposition.**”

### DESCRIPTION

The embryo biopsy is typically performed 5-7 days after the egg retrieval when the embryo has developed to the blastocyst stage. The biopsy of the embryo is performed after making a small opening in the outer shell that surrounds the embryo. In some cases, it may be necessary to take a second biopsy if the testing turns out to be inconclusive. The blastocyst is cryopreserved immediately after biopsy. The biopsy sample is then sent to an outside genetics laboratory for testing. The embryo remains stored frozen in our laboratory while the biopsied cells are being tested in the genetics laboratory. The genetic testing results are usually available 14-21 days. Once the results are known, those embryos reported as chromosomally normal can be transferred in a future thaw cycle.

**The reported results of genetic testing of the embryos can be one of following:**

1. **Embryos reported as Euploid/Chromosomally Normal/Negative for Whole Chromosome Aneuploid:** these embryos are expected to have the typical chromosome numbers needed for normal growth and development and are recommended for transfer.
2. **Embryos reported as Aneuploid/Abnormal/Positive for Whole Chromosome Aneuploid:** these embryos are expected to have an abnormal number of chromosomes, a deletion or duplication or abnormal copy number; they will not be transferred and are typically discarded.
3. **Inconclusive:** these embryos will automatically be thawed, re-biopsied if possible, refrozen and re-tested.

All Embryos will remain in storage until the “**Disposition Consent for Embryos Reported as Whole Chromosome Aneuploid on PGT-A**” is signed by patient(s) indicating discard.

Any embryo that has undergone PGT-A and has been classified as having a *segmental aneuploid* or *mosaic* result will remain frozen until patient completes a “**Consent to Discard Frozen Embryos**”.

### RISKS

Numerous animal studies and some human studies have demonstrated that embryo biopsy does not affect the normal development of the offspring. However, there may be unforeseen risks to the fetus/offspring as a result of this procedure.

Other potential risks of performing the embryo biopsy including and not limited to:

1. The biopsy cannot be performed because the eggs do not fertilize, or the embryos stop developing.
2. The biopsy cannot be performed due to inadequate embryo development.
3. The biopsy renders the embryo non-viable or less likely to implant.
4. Technical problems prevent the embryo biopsy from being accomplished.
5. The biopsied cells obtained are destroyed or lost during transport to the outside laboratory.
6. Genetic testing results indicate that there are no chromosomally normal embryos. For sex selection cases, there may be no embryos of the desired sex.
7. Embryos that are previously frozen may not survive the thawing process.





**PARTNER - 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)**

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**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)**