Chapter 4

Sample Consent Forms

4.1 Consent Form to be signed by the Couple

We have requested the Centre (named above) to provide us with treatment services to help us bear a child.

We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries to raise oocytes have temporary side effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyper-stimulation occurs, where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent, in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

2. There is no guarantee that:

   a. The oocytes will be retrieved in all cases.

   b. The oocytes will be fertilized.

   c. Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.

   All these unforeseen situations will result in the cancellation of any treatment.

3. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are replaced.

4. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.

5. **Endorsement by the ART clinic**

   I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

6. This consent would hold good for all the cycles performed at the clinic.

Name and Signature of the Husband

Name and Signature of the Wife

Name, Address and Signature of the Witness from the clinic

Name and Signature of the Doctor

Dated:

4.2 Consent for Artificial Insemination with Husband's Semen

_____and_____
_____, being husband and wife and both of legal age, authorize Dr._____ to inseminate the wife artificially with the semen of the husband for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

The procedure(s) carried out does (do) not ensure a positive result, nor do they guarantee a mentally and physically normal body. This consent holds good for all the cycles performed at the clinic.

Endorsement by the ART clinic

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature of the Witness from the clinic

Signed: _____ (Husband)
_____ (Wife)

Name and Signature of the Doctor

Dated:

4.3 Consent for Artificial Insemination with Donor Semen

We, _____ and _____, being husband and wife and both of legal age, authorize Dr._____ to inseminate the wife artificially with semen of a donor (registration no._____; obtained from _____ semen bank) for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

We declare that we shall not attempt to find out the identity of the donor.

I, the husband, also declare that should my wife bear any child or children as a result of such insemination (s), such child or children shall be as my own and shall be my legal heir (s).

The procedure(s) carried out does (do) not ensure a positive result, nor do they guarantee a mentally and physically normal body. This consent holds good for all the cycles performed at the clinic.

Endorsement by the ART clinic

I/we have personally explained to _____and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature
of the Witness from the clinic

Signed: _____
(Husband)
(Wife) _____

Name and Signature of the Doctor

Dated:

4.4 Consent for Freezing of Embryos

We _____ and _____ consent to freezing of the embryos that have resulted out of IVF/ICSI with our gametes. We understand that the embryos would be normally kept frozen for five years. If we wish to extend this period, we would let you (the ART clinic) know at least six months ahead of time. If you do not hear from us before that time, you will be free to (a) use the embryos for a third party; (b) use them for research purposes; or (c) dispose them off. We also understand that some of the embryos may not survive the subsequent thaw and that frozen embryo-replaced cycles have a lower pregnancy rate than when fresh embryos are transferred.

*Husband

In the unforeseen event of my death, I would like

The embryos to perish	☐
To be donated to my wife	☐
To be donated to a third party	☐
Used for research purposes	☐

Signed: Dated:

***Wife**

In the unforeseen event of my death, I would like

The embryos to perish	☐
To be donated to my husband	☐
To be donated to a third party	☐
Used for research purposes	☐

Signed Dated :

Endorsement by the ART clinic

I/we have personally explained to _____ and _____the details and implication of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature of the Witness from the clinic

Name and Signature of the Doctor Dated

* The appropriate option may be ticked

4.5 Consent for the Procedure of PESA and TESA

Name of female partner
Name of male partner

We hereby request and give consent to the procedure of PESA and TESA for ICSI, to be performed on the male partner.

We understand that

a) There is no guarantee that the sperm will be successfully removed or that sperm will necessarily fertilise our oocytes.

b) Should the sperm retrieval fail, the following options will be available for the retrieved oocytes.

i) Insemination of all or some oocytes using donor sperm ☐

ii) Donation of oocytes to another infertile couple ☐

iii) Disposal of oocytes according to the ethical guidelines ☐

(Tick the appropriate option)

Each of the above points has been explained to us by _____

The procedure(s) carried out does (do) not ensure a positive result, nor do they guarantee a mentally and physically normal body. This consent holds good for all the cycles performed at the clinic.

Endorsement by the ART clinic

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Signature of Male Partner

Signature of Female Partner

Name, Address and Signature of the Witness from the clinic

Name and Signature of the Doctor

Dated

4.6 Consent for Oocyte Retrieval/Embryo Transfer

Woman's Name:

Woman's Address:
Name of the Clinic:

I have asked the Clinic named above to provide me with treatment services to help me bear a child. I consent to:

a) Being prepared for oocyte retrieval by the administration of hormones and other drugs

b) The removal of oocytes from my ovaries under ultrasound guidance/ laparoscopy

c) The mixing of the following:

☐ My oocytes ☐ the sperm of my husband

☐ Anonymous donor oocyte ☐ anonymous donor sperm

(Tick the appropriate and strike off the others)

d) the placing in my _____ of

e) 1. _____ (no) of the oocytes mixed with the sperm

f) 2. _____ (no) of the resulting embryos

g) 3. _____ (no) of our cryo-preserved embryos

h) 4. _____ (no) of embryo (s) obtained anonymously

I had a full discussion with _____ about the above procedures and I have been given oral and written information about them.

I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general/regional/sedation) has been discussed in terms which I have understood.

Endorsement by the ART clinic

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Signature of Female Partner

Name, Address and Signature
of the Witness from the clinic

Name and Signature of the Doctor

Dated

4.6.1 Consent of Husband

As the husband, I consent to the course of the treatment outlined above. I understand that I will become the legal father of any resulting child, and that the child will have all the normal legal rights on me.

Name, Address & Signature : _____
(Husband)

Name, Address and Signature
of the witness from the clinic: _____

Name and Signature of the Doctor: _____

Dated

4.7 Agreement for Surrogacy

I, _____ (the woman), with the consent of my husband (name), of _____ (address) have agreed to act as a host mother for the couple, _____ _____ (wife) and _____ (husband), both of whom are unable (or do not wish to) to have a child by any other means.

I had a full discussion with _____of the clinic on _____ in regard to the matter of my acting as a surrogate mother for the child of the above couple.

I understand that the methods of treatment may include:

1. Stimulation of the genetic mother for follicular recruitment
2. The recovery of one or more oocytes from the genetic mother by ultrasound-guided oocyte recovery or by laparoscopy.
3. The fertilisation of the oocytes from the genetic mother with the sperm of her husband or an anonymous donor.
4. The fertilisation of a donor oocyte by the sperm of the husband.
5. The maintenance and storage by cryopreservation of the embryo resulting from such fertilisation until, in the view of the medical and scientific staff, it is ready for transfer.
6. Implantation of the embryo obtained through any of the above possibilities into my uterus, after the necessary treatment if any.

I have been assured that the genetic mother and the genetic father have been screened for HIV and hepatitis B and C before oocyte recovery and found to be seronegative for all these diseases. I have, however, been also informed that there is a small risk of the mother or/and the father becoming seropositive for HIV during the window period.

I consent to the above procedures and to the administration of such drugs that may be necessary to assist in preparing my uterus for embryos transfer, and for support in the luteal phase.

I understand and accept that there is no certainty that a pregnancy will result from these procedures.

I understand and accept that the medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal and living child.

I am unrelated/related (relation) _____ to the couple (the would be genetic parents).

I have worked out the financial terms and conditions of the surrogacy with the couple in writing and an appropriately authenticated copy of the agreement has been filed with the clinic, which the clinic will keep confidential.

I agree to hand over the child to _____ and _____ , the couple (to _____ in case of their separation during my pregnancy, or to the survivor in case of the death of one of them during pregnancy) as soon as I am permitted to do so by the Hospital/Clinic/Nursing home where the child is delivered.

I undertake to inform the ART clinic, _____, of the result of the pregnancy.

I take no responsibility that the child delivered by me will be normal in all respects. I understand that the biological parents of the child have a legal obligation to accept their child that I deliver and that the child would have all the inheritance rights of a child of the biological parents as per the prevailing law.

I will not be asked to go through sex determination tests for the child during the pregnancy and that I have the full right to refuse such tests.

I understand that I would have the right to terminate the pregnancy at my will; I will then refund all certified and documented expenses incurred on the pregnancy by the biological parents or their representative. If, however, the pregnancy has to be terminated on expert medical advice, these expenses will not be refunded.

I have been tested for HIV, hepatitis B and C and shown to be seronegative for these viruses just before embryo transfer.

I certify that (a) I have not had any drug intravenously administered into me through a shared syringe; (b) I have not undergone blood transfusion; and (c) I and my husband have had no extramarital relationship in the last six months.

I also declare that I will not use drugs intravenously, undergo blood transfusion excepting of blood obtained through a certified blood bank, and avoid sexual intercourse during the pregnancy.

I undertake not to disclose the identity of the couple.

In the case of the death of both the husband and wife (the couple) during my pregnancy, I will deliver the child to _____ or _____ in this order; I will be provided, before the embryo transfer into me, a written agreement of the above persons to accept the child in the case of the above-mentioned eventuality.

Endorsement by the ART clinic

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Signed:
(Surrogate Mother)

Name, Address and Signature
of the Witness from the clinic

Name and Signature of the Doctor

Dated

4.8 Consent Form for the Donor of Eggs

I Ms. _____ consent to donate my eggs to couples who are unable to have a child by other means.

I have had a full discussion with Dr. _____ (name and address of the clinician) on _____.

I have been counselled by _____ (name and address of independent counsellor) on _____.

I understand that there will be no direct or indirect contact between me and the recipient, and my personal identity will not be disclosed to the recipient or to the child born through the use of my gamete.

I understand that I shall have no rights whatsoever on the resulting offspring and vice versa.

I understand that the method of treatment may include:

- Stimulating my ovaries for multifollicular development.
- The recovery of one or more of my eggs under ultrasound-guidance or by laparoscopy under sedation or general anesthesia.
- The fertilization of my oocytes with recipient's husband's or donor sperm and transferring the resulting embryo into the recipient.

Endorsement by the ART clinic/oocyte bank

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Signed: _____

Name, Address and Signature of the Witness from the clinic

Name and Signature of the Doctor

Dated

4.9 Consent Form for the Donor of Sperm

I Mr. _____ consent to donate my sperm to couples who are unable to have a child by other means.

I have had a full discussion with Dr. _____ (name and address of the clinician) on _____.

I have been counselled by _____ (name and address of independent counsellor) on _____.

I understand that there will be no direct or indirect contact between the recipient, and me and my personal identity will not be disclosed to the recipient or to the child born through the use of my gamete.

I understand that I shall have no rights whatsoever on the resulting offspring and vice versa.

Endorsement by the ART clinic/semen bank

I/we have personally explained to _____ and _____ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Signed: _____

Name, Address and Signature
of the Witness from the clinic

Name and Signature of the Doctor Dated