

OREGON HEALTH SCIENCES UNIVERSITY  
Division of Reproductive Endocrinology and Infertility  
**FREEZING (CRYOPRESERVATION) OF EMBRYOS**  
**INFORMED CONSENT**

We, \_\_\_\_\_ (patient) and \_\_\_\_\_ (partner),  
have consented to attempt to become pregnant using in vitro fertilization and embryo transfer.  
We understand that the following itemizes what will be done with our frozen embryos.

We understand that as a result of our participation in the in vitro fertilization (IVF)/gamete intra fallopian transfer (GIFT) program, more embryos may result than our physicians recommend be transferred in the IVF/GIFT cycle. We wish that these extra embryos, regardless of their number, be frozen. We understand that there is no guarantee that the embryos will survive the freezing or thawing process nor that pregnancy will occur. We also understand that rare equipment failures or laboratory accidents can occur at any point in the process resulting in loss of the embryos. We understand that the embryos are subject to our joint disposition and, therefore, that all decisions about their disposal must be joint decisions, except where such disposal may be affected by applicable laws in the future or by any court decision having jurisdiction over these embryos, or by the death of one of us or by divorce.

We understand that there is no indication of any increase in the rate of abnormalities in children born after cryopreservation. We understand that until very large numbers of children have been born following freezing of embryos, the actual rate of abnormalities is unknown. We accept this uncertainty and acknowledge that any abnormality of a child conceived through this procedure is not the responsibility of the Oregon Health Sciences University.

We understand that when we are ready to have embryos transferred they will be thawed and evaluated.

Our questions about embryo freezing have been answered to our satisfaction by the IVF team and we consent voluntarily to have embryos frozen as is appropriate for our IVF cycle.

\_\_\_\_\_  
Signature of Female Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Male Partner

\_\_\_\_\_  
Signature of Witness (Other than Physician)

*Note: This consent form must be signed by patient and partner in the witness of an Oregon Health Sciences University employee whenever possible.*