Obstetrics & Gynecology
Strong Fertility Center

UR MEDICINE
Medicine of the Highest Order

Oocyte Thaw Consent Form

I _____ (patient)

wish to have some/all of my cryopreserved (frozen) oocytes thawed in an attempt to initiate a pregnancy in myself.

Some or all of my oocytes may not survive the thawing process. The determination of oocyte viability after thawing will be made by the IVF laboratory. Information regarding the long-term effects of oocyte cryopreservation of the resulting children is not available, but information to date does not indicate any increase in birth defects or other problems.

Equipment malfunction or technical error may occur and result in oocyte loss.

I acknowledge that I have had an opportunity to ask questions and have had them answered to my satisfaction.

X _____ _____
Patient Signature **Date**

_____ _____
Patient Name **Date of Birth**

Notary Public _____ **Date** _____

500 Red Creek Drive · Suite 220 · Rochester, NY 14623
585.487.3378 · 585.334.8998 fax · www.fertility.urmc.edu