Department of Obstetrics and Gynecology
Strong Fertility Center

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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 or a gestational carrier.

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 on 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.

Please check plan below for lab to Thaw accordingly:

☐ **Plan to Thaw, Fertilize & Transfer:**

- **Number of oocytes to be thawed _____**
- **Number of oocytes to be fertilized _____**
  - ☐ **Partner Name _____ DOB:_____**
  - ☐ **Sperm Donor Bank and ID # _____**
- **Number of embryo(s) to be transferred _____**

☐ **Plan to Thaw, Fertilize & Biopsy for genetic testing (PGT-A/PGT-M):**

- **Number of oocytes to be thawed _____**
- **Number of oocytes to be fertilized _____**
  - ☐ **Partner Name _____ DOB:_____**
  - ☐ **Sperm Donor Bank and ID # _____**

X _____ _____
Patient Signature Date

_____ _____
Patient Name Date of Birth

X _____ _____
Notary/Clinic Witness (RN, APP, MD) Signature Date

_____
Printed Name