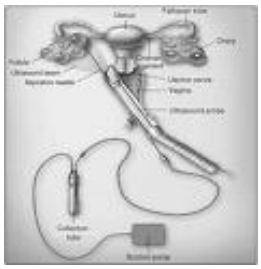
THE FERTILITY CENTER, LLC
CONSENT FORM
OOCYTE RETRIEVAL

PURPOSE

By signing this document, I give permission to the physicians of The Fertility Center, LLC (Dr. Robert Filer or Dr. Richard Meter) to perform oocyte retrieval in order to collect oocytes from my ovaries in hopes of achieving fertilization in the IVF laboratory. This document confirms that I have been previously advised about the procedure, the risks, complications and alternatives. My signatures at the conclusion of this document certifies that you have been provided information about IVF treatment and the oocyte retrieval including how the procedure is performed, its risks, complications and alternatives. My signature further certifies that I have discussed treatment including this oocyte retrieval with the IVF team and that I have received satisfactory answers thereto. Finally, my signatures certify that I have read this document in its entirety.



Patient: _____ Birth Date:_____

1. I hereby request and authorize Dr. Robert Filer or Dr. Richard Meter and their associates, assistants and/or designees to perform upon me transvaginal ultrasound guided oocyte retrieval. This procedure involves the retrieval of eggs from ovarian follicles via a needle. Usually, the needle is introduced through the vagina and into the ovary. However, if necessary, retrieval of eggs from ovarian follicles may occur via a needle introduced through the bladder and then into the ovary.
2. I am aware of how the procedure is performed, its purpose, risks, complications and alternatives.
3. I am aware that the risks of the procedure include but are not limited to:
    - The needle may enter the bowel or a major blood vessel which may result in further complication and/or require major surgery.
    - There may be a reactivation of or a resulting pelvic infection or abscess.
    - The needle may pass through the uterus.
    - The needle may enter the bladder with resulting blood in the urine or an infection in the bladder.
    - Risks attendant to any surgical procedure including severe loss of blood, infection, cardiac arrest, and risks associated with anesthesia.
    - It may be impossible to obtain any eggs, the eggs obtained may not be mature or the eggs may become contaminated.

4. I am aware that the practice of medicine and surgery is not an exact science and results cannot be anticipated or guaranteed. I acknowledge that no guarantees have been made to me concerning the results of the procedure and/or whether it will occur without complication.
5. In giving my authorization for this procedure, I am aware that I am authorizing Dr. Robert Filer or Dr. Richard Meter or any one of their associates, assistants or designees to perform this procedure upon me.
6. I am aware that I will receive anesthesia in the form of intravenous sedation and analgesia. I am aware that an intravenous line will be necessary to administer this anesthesia. The complications related to the use of this anesthesia include mild discomfort and/or development of a bruise at the needle site. Common side effects of the sedation medication include drowsiness, nausea and vomiting, dizziness and hypotension. The intravenous line may result in continued bleeding from the site necessitating pressure or suturing as a possible allergic reaction.
7. I am aware that during the course of the procedure, unforeseen conditions may be revealed necessitating change or extension of the original procedure, or an additional and/or different procedure(s). I authorize, consent to, and request that Dr. Robert Filer or Dr. Richard Meter or any of their associates, assistants or designees perform such change, extension, and additional and/or different procedure as are necessary in the reasonable extension of professional judgment.
8. I certify that The Fertility Center, LLC has provided me with information about IVF treatment and this procedure which I have read.
9. I certify that I have read and fully understand this consent statement.
10. I certify that I have discussed this procedure with the IVF team members and that all of my questions regarding this procedure have been answered to my satisfaction.
11. I agree not to revoke, limit or alter this consent except in writing signed by me and delivered to my primary physician prior to the commencement of the procedures described herein. I understand that I am free to withdraw any portion of my consent at any time prior to this procedure.

- ❑ I have read the form or have had it read to me.
- ❑ I expressed understanding of this form.
- ❑ I have no further questions.

_____ _____ _____ _____

Signature of Patient Date Signature of Witness Date

_____ _____

Signature of Physician Date

Revised 2/1/2009