Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

CONSENT TO USE REPRODUCTIVE CELL OR TISSUE FROM AN EMBRYO DONOR DETERMINED TO BE EXEMPT

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

I/We ______________________________ have been informed that our Reproductive Donor of Embryos does not meet established screening or testing criteria by FDA due to:

- ☐ Embryos were frozen before May 25, 2005
- ☐ Embryos were frozen with no intention to transfer to a gestational carrier

These criteria are meant to minimize the risk of spreading communicable diseases.
The departure (s) is/are:

Infectious diseases testing done at the time of oocyte retrieval but FDA Testing performed after oocyte retrieval and embryos were cryopreserved for

- ☐ *Oocyte donor*
- ☐ *Sperm donor*

The possible consequence(s) of having these embryos transferred could be:

Minimal risk of infection

We are aware the reproductive tissue will be labeled as follows:

Exempt/ advised of subsequent testing

COPY TO LABORATORY TO ENSURE PROPER LABELING OF SAMPLES

After discussing with my/our physician the possible consequences of having these embryos transferred, I/We have decided to accept the above risks and go forward with the transfer. I am aware that screening and testing of the donors were not performed at the time of cryopreservation of the reproductive cells or tissue, but have been performed subsequently I/we hereby authorize Lucile Salter Packard Children's Hospital at Stanford to proceed with the transfer of these into my uterus:

Gestational Carrier______________________________ Date______________

Gestational Carrier Partner______________________________ Date______________

Physician______________________________ Date______________

Intended Parent______________________________ Date______________

Intended Parent______________________________ Date______________

Physician______________________________ Date______________