Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

CONSENT TO USE DONATED EMBRYO CELL OR TISSUE

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 with no intention to donate to another couple or individual

Embryos Donated through: ❑ _____Embryo Bank ❑ Directed Donation

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 the recipient's uterus:

Recipient Signature/Gestational Carrier	Print Name	Date	Time
Partner or Gestational Carrier/Recipient Signature	Print Name	Date	Time
Individual Donating Embryos Signature	Print Name	Date	Time
Individual Donating Embryos Signature	Print Name	Date	Time

DATE	TIME	Physician Signature:		
		PRINT Name:	Credentials	Pager Number, if applicable