

**CONSENT FORM FOR TRANSFER OF FROZEN/THAWED EMBRYOS**

We \_\_\_\_\_, wish to try to achieve a pregnancy by means of transferring previously frozen embryos to the woman's body. We agree that all or some of the embryos will be thawed. Each embryo will be examined to determine if it is medically appropriate to transfer to her body. If after thawing, the embryos do not appear to be viable; those embryos will not be transferred back to her body.

Scientific surveys of the offspring from embryos that were cryopreserved have found no increase in the rate of birth defects.

Date\_\_\_\_\_ Time\_\_\_\_\_ Signature of Patient\_\_\_\_\_

Date\_\_\_\_\_ Time\_\_\_\_\_ Signature of Patient's Partner\_\_\_\_\_

Date\_\_\_\_\_ Time\_\_\_\_\_ Signature of Witness\_\_\_\_\_

Date\_\_\_\_\_ Time\_\_\_\_\_ Signature of Physician\_\_\_\_\_