40647

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

AUTHORIZATION FOR THE USE OF FROZEN SPERM - PARTNER

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

I _____authorize the use of my frozen sperm sample to fertilize
(print Partner's name)
oocytes (eggs) in the Women & Infants Fertility Center (WIFC) laboratory with the intent of having a child with _____.
(print Patient's name)

I understand that this authorization is valid for the current treatment cycle at WIFC. If additional cycles are pursued, I will need to sign another authorization.

I understand that authorization to store and use frozen sperm is also required by the Andrology Laboratory.

I understand that evaluation, including tests for HIV and hepatitis, will be performed as a routine part of this process. Other studies as indicated by medical and/or family history may be obtained.

In the hope that I may help others, I donate for teaching or research purposes the specimens obtained during my medical treatment which otherwise would be routinely discarded. I understand that by agreeing to this donation there is no additional risk to me. I also understand that I may refuse and the treatment given would not be affected.
My limitations are: _____

I understand that Women & Infants Hospital is a teaching hospital where fellows, residents and advanced practicing medical and nursing students may observe and/or perform IVF and its related procedures under the direct supervision of licensed practitioners of accredited teaching programs.

I have had the opportunity to ask questions which have been answered to my satisfaction.

Partner Signature: _____ Witness Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

For Partner's Signature if not signed at WIFC

STATE OF _____
COUNTY OF _____

Then personally appeared before me the above named _____, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of _____, 20____.

NOTARY PUBLIC: _____
MY COMMISSION EXPIRES: _____

40735

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

PATIENT CONSENT FOR FERTILITY TREATMENT DURING COVID-19 AT WOMEN & INFANTS FERTILITY CENTER

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

C19-40735 (5-2020)

COVID-19 has been declared a worldwide pandemic by the World Health Organization. Although the exact mode of transmission is not entirely known, COVID-19 is contagious and is believed to spread by person-to-person contact. Despite taking reasonable preventative measures that are aimed to prevent the spread of COVID-19, an inherent risk of becoming infected with COVID-19 by virtue of proceeding with fertility treatment still exists.

By seeking treatment at Women & Infants Fertility Center I _____
(Patient's Name)

(or _____ for _____)
(Legal Guardian) (Patient's Name)

and _____ (if applicable) acknowledge and understand:
Partner's Name

1. Despite all precautions offered to me/us or taken by my/our providers, there is no guarantee that I/we will not be exposed to and/or infected with COVID-19.
2. Use of personal protective equipment (PPE) can minimize risk but does not eliminate the risk of transmission of COVID-19.
3. Possible exposure to COVID-19 may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and/or the risk of death.
4. The impact of COVID-19 on pregnancy for both the mother and baby is not fully known. I/we acknowledge that any febrile illness in early pregnancy may increase the risk of miscarriages and birth defects and that pregnant women appear to be at greater risk of severe complications from other respiratory viral infections such as influenza.
5. Even if I/we have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus, there is a chance I/we may have contracted COVID-19 after the test and I/we acknowledge that I/we may still transmit the undetected virus to another person.
6. My/Ourtreatment/procedure may be delayed or canceled should I/we develop symptoms, be tested positive for COVID-19 or for a variety of others reasons including changing regulations and restrictions surrounding COVID-19, availability of staff, the availability of adequate PPE or other reasons. If treatment is modified or canceled this can interfere with the ability to become pregnant through treatment as well as have financial consequences including not being reimbursed for expenses already incurred.
7. I/we are expected to follow reasonable precautions set forth by the WIFC such as wearing a facemask at all times in the clinic and to observe social distancing and proper handwashing both inside and outside of the clinic during the course of treatment.
8. These precautions may also include the request to self-quarantine and to pursue any testing for patient, or partner if applicable, related to COVID-19 before treatment. I/we understand that it may be necessary to obtain this testing at an outside lab and there may be extra costs associated with this testing.
9. Failure to comply with these requests, follow recommended precautions, as well as exposure to, developing symptoms of, or testing positive for COVID 19 may result in the delay or cancelation of treatment.
10. If treatment is delayed or canceled, this can have financial consequences including not being reimbursed for expenses already incurred.

11. The staff at WIFC is providing fertility treatment and I/we are responsible for obtaining other healthcare needs through other providers including routine gynecologic and primary care, any ongoing obstetric care, and any care related to COVID-19.
12. I/we have the option to postpone fertility treatment to minimize the risk of acquiring COVID-19.

I/we have been counseled about resources available to provide further information about COVID-19. I /we have had the opportunity to read this form, or have it read to me/us, and I/we understand it. I/we have had the opportunity to ask questions and they have been answered to my/our satisfaction. Understanding all of the above, I/we desire to proceed with fertility treatments.

Time: _____ AM / PM Date: _____ Signature: _____
(Patient or Legal Guardian)

Relationship: _____

Time: _____ AM / PM Date: _____ Signature: _____
Partner, if applicable

Provider's Acknowledgement:

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Provider)

Print Name: _____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Interpreter)

Print Name: _____
(Interpreter)

For Partner's Signature if not signed at WIFC

STATE OF _____

COUNTY OF _____

Then personally appeared before me the above named _____, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of _____, 20____.

NOTARY PUBLIC: _____
MY COMMISSION EXPIRES: _____