40643

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

CONSENT FOR ASSISTED HATCHING

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 _____ and _____
(Print Patient's name) (Print Partner's name, if applicable)

consent for the embryology staff at Women and Infants Fertility Center (WIFC) to perform assisted hatching on my/our embryo(s) if the embryology staff determines that the procedure will improve the chance of pregnancy.

I/we understand that the embryology staff will examine the zona pellucida (the shell-like layer surrounding the embryo) and the general appearance of each embryo to determine whether assisted hatching may be indicated for embryos selected for transfer.

I/we understand that the natural process of embryo hatching involves the embryo shedding its zona pellucida so it can implant into the lining of the uterus. When performing assisted embryo hatching, the embryology staff uses a laser to weaken the zona pellucida to help the embryo(s) shed this layer.

The risks of the assisted hatching procedure have been discussed with me/us, and I/we understand them. I/we understand that complications can happen as a result of assisted hatching. Complications may include, but are not limited to the following:

- Damage to the embryo(s). I/we understand that any embryo(s) damaged as a result of assisted hatching will not be transferred to attempt a pregnancy.
- Multiple gestations (more than one baby). Research has reported an increase in identical twins when using this procedure.

I/we understand that the lists of risk and complications related to the above procedures are not complete and that my/our physician has discussed with me/us that other unforeseen risks do exist and that additional procedures may be required. I/we consent to those procedures which my/our physician deems necessary.

I/we are aware that the practice of medicine is not an exact science. I/we acknowledge that no guarantee or promise has been given to me/us by anyone as to the results of this procedure.

I/we acknowledge and agree that I/we are responsible for all costs and fees associated with Assisted Hatching.

I/we acknowledge that this form has been explained and I/we understand its contents. I/we have had the opportunity to ask questions which have been answered to my/our satisfaction.

Time: _____ A.M./P.M. Date: _____ Signature: _____
Patient

Time: _____ A.M./P.M. Date: _____ Signature: _____
Partner, if applicable

Provider's Acknowledgement:

I confirm that consent, as described above, has been given by the patient, (and partner, if applicable.)

Time: _____ A.M./P.M. Date: _____ Signature: _____
(Provider)

Print Name:_____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by the patient, (and partner, if applicable.)

Time: _____ A.M./P.M. 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: _____

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: _____