



**CONSENT FOR INTRACYTOPLASMIC  
SPERM INJECTION (ICSI)**

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 Clinic (WIFC) to perform intracytoplasmic sperm injection (ICSI). I/we understand that ICSI is a procedure where a single sperm is placed directly into the oocyte (egg) using a microscopic needle in an effort to increase the likelihood of fertilization. The clinical decision to proceed with ICSI is made by the physician/embryology staff based on sperm and/or egg quality and/or quantity.

I/we understand that ICSI may be performed in the event of any of the following, and as deemed necessary by the WIFC team to improve the chances of achieving pregnancy:

- low sperm count
- low sperm motility (speed)
- poor sperm shape/size
- use of frozen sperm
- use of donor sperm
- use of surgically retrieved sperm
- past history of sub-optimal fertilization in a prior IVF cycle
- low egg yield
- use of donor eggs
- use of cryopreserved (frozen) eggs.

There may be other indications where ICSI may be justified, including in pre-implantation genetic testing.

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

- Failure of fertilization – I/we understand that there is no guarantee that fertilization will occur. If fertilization fails, I/we understand that pregnancy will not occur in this cycle.
- Birth defects and ICSI – My/our physician has explained that some literature suggests that there may be an increased risks of birth defects in children conceived from ICSI compared to those conceived with traditional IVF (or naturally). It is also possible that any already existing genetic conditions or problems with the chromosomes of the sperm (such as those that may be associated with abnormal sperm) may be passed on to male children born from ICSI.
- Damage to the egg(s)

I/we understand that ICSI, as well as all assisted reproductive technologies, may increase the chances of

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multiple gestations (more than one baby), including identical and non-identical twin pregnancies.

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 for ICSI.

I/we acknowledge that this form has been explained to me/us 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)

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PATIENT NAME: \_\_\_\_\_

DOB OR MR #: \_\_\_\_\_

**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/Our treatment/procedure may be delayed or canceled should I/we develop symptoms, be tested positive for COVID-19 or for a variety of other 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 cancellation 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: \_\_\_\_\_