40252

MR-287 (5-2020)

WOMEN & INFANTS HOSPITAL
101 Dudley Street • Providence, RI 02905

CONSENT FOR OVULATION INDUCTION

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, ____________________________________have requested treatment by the physicians and staff of
(Print Patient's name)
the Women & Infants Fertility Center (WIFC) for the purpose of attempting a pregnancy. I understand that alternative options and the risks and benefits of these alternative options have been explained to me by WIFC, including procedures that are not performed at WIFC, and other non-medical options such as adoption or non-treatment, and I understand them. I consent to allow the WIFC physicians and staff to perform ovulation induction (OI) as outlined in the document below.

I understand, acknowledge, and agree that preconception testing such as for infections and inheritable conditions have been offered as well as the opportunity to discuss these results prior to pursuing treatment. I understand that, regardless of any testing performed, there is still a small risk of transmission with infectious diseases or other undesirable outcomes.

Medications (hyperstimulation), monitoring and blood tests.

The use of "fertility drugs," such as clomiphene citrate, Letrozole, GnRH-agonists, gonadotropins, GnRH-antagonists, and human chorionic gonadotropin (hCG) has been explained to me, and their respective risks and side effects have been discussed. I understand that some of these drugs may be used "off label" (not approved by the FDA for this use). I am aware that some of these medications are administered by injection and may cause bruising and discomfort at the injection site.

I understand that complications may arise as a result of taking fertility drugs. Complications from taking these medications include, but are not limited to:

- infection
- ovarian enlargement and/or Ovarian Hyperstimulation Syndrome (OHSS) *
- damage to the ovaries possibly necessitating removal
- adverse or allergic drug reaction
- very rarely, blood clots, stroke, heart attack, and/or death

My physician has discussed with me and I understand that Ovarian Hyperstimulation Syndrome (OHSS) can be a serious risk/complication from taking fertility drugs. Symptoms of OHSS include increased ovarian size, ovarian torsion (twisting of the ovary), nausea and vomiting, accumulation of fluid in the abdomen, breathing difficulties, an increased concentration of red blood cells, kidney and liver problems, and in the most severe cases, blood clots, kidney failure, or death. In severe form of OHSS, serious complications may require hospitalization and medical and/or surgical interventions. If my physician thinks that I am at risk for severe OHSS, I am aware that my cycle may be canceled.

I acknowledge the importance of maintaining close contact with WIFC during the period of time while I receive these medications and for a minimum of two (2) weeks afterwards. While taking any of the above medications, I may be monitored by WIFC with blood tests and/or transvaginal ultrasounds which may be recommended daily. This blood monitoring carries the risk of mild discomfort and bruising at

the venipuncture (blood draw) site. The ultrasound examinations may be associated with some discomfort.

Fertilization of eggs with sperm

I understand that fertilization occurs via sexual intercourse or through intrauterine insemination (placing sperm inside of my uterus) if appropriate.

Post-OI Management

I understand that taking fertility drugs increases the risk of multiple gestations (more than one baby). The risks of multiple gestations include, but are not limited to:

- preterm labor and the delivery of premature infants that may require intensive care and may have long- term complications associated with prematurity
- pregnancy-induced diabetes
- pre-eclampsia (a dangerous elevation of blood pressure during pregnancy)
- miscarriage

I am aware that pregnancies resulting from OI are subject to the same risks and complications as pregnancies achieved without medical intervention, including but not limited to:

- ectopic pregnancy (pregnancy occurring outside of my uterus and is life threatening)
- preterm labor
- pregnancy with birth defects
- miscarriage
- stillbirth

I acknowledge that WIFC cannot guarantee the health of any infant resulting from this procedure.

I understand that there is no guarantee that a pregnancy will occur as a result of this treatment. My physician has discussed with me the chance of a successful outcome.

General Ovulation Induction Consent Provisions

I acknowledge that the physicians at the Women & Infants Fertility Center are only managing my infertility and that I am responsible for obtaining my general medical and gynecologic care through other physicians.

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

I consent to the taking of photographs, videotapes and/or illustrations of my procedures. and other medical problems for diagnostic purposes, or educational or scientific purposes, provided my identity is not revealed.

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WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ___________________________

DOB OR MR #: ____________________________

I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantee or promise has been given to me by anyone as to the results of my treatment. I understand that the above procedures.

I acknowledge that this form has been explained to me and I understand its contents. I understand that this consent is valid for one (1) year from the date of signing. I understand that at any point in the year any signing party may revoke consent by certified letter to WIFC. I have had the opportunity to ask questions which have been answered to my satisfaction.

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
Patient

Partner's Acknowledgement (if applicable)

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
Partner

Print Name: ______________________________

Provider's Acknowledgement:

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

Time: ______ A.M./P.M. Date: ______________ Signature: ________________________________
(Interpreter)

Print Name:______________________________
(Interpreter)

For Partner's Acknowledgment 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

C19-40735 (5-2020)

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 #: ______________________

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: ____________________________