



EMBRYO WARMING, BIOPSY/RE-BIOPSY AND RE-VITRIFICATION CONSENT

By signing this consent, I/we are electing to have our cryopreserved embryo(s) warmed, biopsied or re-biopsied, analyzed by PGT-A or PGT-M technology and re-vitrified. I/we understand that there is a chance that the embryo(s) will not survive the warming, biopsy/re-biopsy, re-vitrifying or re-warming procedures prior to a Frozen Embryo Transfer (FET) and that no embryos may be available for transfer. Furthermore, the risks remain the same as with the initial freezing, biopsy and analysis; as outlined in the original consents. Risks include damage to the embryo from warming, biopsy and re-vitrification. Risks exist with shipping of the samples and delays that could impact analysis. I/we are also aware of the possibility of a repeat inconclusive result from the PGT analysis. PGT-A analysis provides a report of chromosome number from the biopsied cell/s of the embryo. PGT-M analysis provides a report on a single gene defect from the biopsied cell/s of the embryo. There is a possibility that a misdiagnosis could be made and that a chromosomally or genetically normal embryo could be diagnosed as abnormal, or conversely, that a chromosomally or genetically abnormal embryo could be misdiagnosed as normal, be transferred and could result in miscarriage or in an ongoing clinical pregnancy. I/we understand that as a result of this testing that no embryos may be available for transfer based on the chromosome or genetic report. I/we also understand that an insufficient number of babies have been born to confirm that the re-biopsy procedure and/or the re-vitrification procedure is without risk to the embryo/offspring.

I/we, the undersigned, have read this document; understand the purposes, risks, and benefits of this procedure and have been given the opportunity to ask questions about it, which have been answered to our satisfaction. I/we consent to having our embryos thawed and biopsied for use in preimplantation genetic testing.

Patient:

Date: _____ DOB: _____

Patient Name: _____

Patient Signature: _____

MGH Staff printed name: _____

MGH Staff Signature: _____

Partner (if applicable):

Date: _____ DOB: _____

Partner Name: _____

Partner Signature: _____

MGH Staff printed name: _____

MGH Staff Signature: _____

NOTARY (required if not witnessed by MGH staff)

County of _____ On this _____ day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

Notary Signature: _____

Date: _____ Commission Expiration Date: _____

(Seal)

NOTARY (required if not witnessed by MGH staff)

County of _____ On this _____ day of _____, 20 _____, before me the undersigned notary public, personally appeared _____, provided to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

Notary Signature: _____

Date: _____ Commission Expiration Date: _____

(Seal)