

FORM 12

[See rule 13 (f) (vii)]

Consent for Oocyte Retrieval

Name(s) and address(es) of patient Patient Name, Patient address

Name and address of the Clinic: Clinic Name, Clinic address

I have asked the Clinic named above to provide me with treatment services to help me bear a child. I consent to:

1. Being prepared for oocyte retrieval by the administration of hormones and other drugs
2. The removal of oocytes from my ovaries under ultrasound guidance / laparoscopy

I/We had a full discussion with ...~~Doctor~~xyz..... about the above procedures and the risks and complications involved and I have been given oral and written information about them I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

I/We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I/We have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general / regional / sedation) has been discussed in terms which I have understood.

Signature of intending couple/ intending woman