MASSACHUSETTS GENERAL HOSPITAL FERTILITY CENTER

AGREEMENT AND CONSENT TO PERFORM THERAPEUTIC DONOR INSEMINATION WITH KNOWN (NON-INTIMATE) DONOR SPERM

Female Name: _____ **MRN#**:_____

Partner Name: _____ **MRN#**:_____

This document explains the terms under which I, the female patient undergoing insemination, agree and consent to the performance of one or more therapeutic insemination(s) with sperm from a non-intimate known donor, by the staff of the Massachusetts General Hospital Fertility Center. The Massachusetts General Hospital Fertility Center is signing this Agreement. If I am entering fertility treatment with my husband/partner, my husband/partner's agreement and consent to participate in this process are also required. My husband/partner's signature on this document signifies that my husband/partner has read and understands this document and fully and freely agrees to participate in the Fertility Center program as described below.

Therapeutic Insemination:
The therapeutic insemination procedure, its risks, benefits, and alternatives have been explained to us (me) by the staff of the Massachusetts General Hospital Fertility Center. Therapeutic Donor Insemination involves attempting to create a pregnancy, either through intrauterine insemination (placing the sperm directly in my uterus) or in vitro fertilization (combining the sperm with my or a donor egg(s) in the lab and then placing the resulting embryo(s) in my uterus), using sperm from a donor. We (I) have elected to use a non-intimate, known sperm donor selected by us (me).

We (I) consent to any blood tests, infectious disease or genetic testing and any other tests, interviews or screening required for donor insemination. We (I) understand that the cost of this testing will be born by us (me). We (I) understand that donors are screened for infectious diseases, genetic diseases and family history of transmissible diseases. In spite of this screening, we (I) understand that there is, nonetheless, a risk that these diseases or conditions may be transmitted to the sperm recipient, her partner and/or a child. We understand that the Massachusetts General Hospital Fertility Center will follow FDA guidelines in verifying that the donor that appropriate communicable disease screening has been performed. We (I) understand that the sperm must be quarantined for 6 months in an FDA registered sperm storage facility and the non-intimate known donor must be rescreened at that time prior to using his sperm. It is possible that he may not be eligible based on this repeat screening process and his sperm will not be used.

We (I) understand that if the sperm bank is not registered or appropriate screening has not been performed, the donor sperm insemination will not be performed. We (I) agree to notify the Massachusetts General Hospital Fertility Center of any genetic disease that occurs in a child conceived by these inseminations. We (I) understand that there is no guarantee that these inseminations will result in a pregnancy. We (I) further understand

that within the normal human population a certain percentage (approximately 3%) of children are born with physical or mental defects and that the occurrence of such defects is beyond the control of physicians. We (I) therefore understand and agree that the Massachusetts General Hospital Fertility Center and its physicians do not assume responsibility for the physical and mental characteristics of any child or children born as a result of therapeutic insemination. We (I) also understand and accept that any pregnancy carries with it the risk of obstetrical complications and/or spontaneous abortion.

We (I) understand that if donor sperm is used for *intrauterine insemination,* this will involve placing the donor sperm into the cervix or uterus using a small sterile catheter (straw-like device) attached to a syringe. This procedure may cause mild cramping or spotting. There is a small risk of pelvic infection from the procedure, but this is rare. If the donor sperm is used as part of an *in vitro fertilization* treatment, the sperm will be used to inseminate oocytes based on your treatment regimen.

We (I) understand that the sperm will be stored in liquid nitrogen tanks for subsequent use. We (I) agree not to make any claim against the hospital or its employees for damage or loss resulting from any equipment malfunction, loss of power, or other event not caused by negligence of a hospital employee.

Further Acknowledgements and Agreements:

As appropriate, it is further agreed that from conception, I, the patient's legal spouse, accept the act of insemination as my own and understand:

a. That such child or children conceived or born shall be considered to be my legitimate children and heirs, and;

b. That I hereby waive forever any right which I might have to disclaim or omit the child or children as my legitimate heir or heirs, and;

c. That such child or children conceived or born shall be considered to be in all respects, including descent and distribution of my property, a child or children of my body, and;

d. That I may be contacted periodically to verify my continued consent to participate in this treatment.

We (I) further agree that we (I) will not seek support or any other payment from the donor, physician, or the Massachusetts General Hospital Fertility Center for any child or children born through this therapeutic insemination. We further agree that, if the child or children should seek support or any of payment from the donor, the physician, or the Massachusetts General Hospital Fertility Center, we will indemnify and hold harmless the donor, the physician, and the Massachusetts General Hospital Fertility Center. We agree and consent that the partner/husband (if applicable) signing this consent may be contacted periodically by mail or during visits to the Massachusetts General Hospital Fertility Center to verify his/her continued participation and consent to this treatment and that he/she may withdraw his/her consent at any time prior to the therapeutic

insemination procedure by notifying the Massachusetts General Hospital Fertility Center in writing.

We (I) understand that insurance coverage for any or all of the above procedures may not be available and that we (I) will be personally responsible for the expenses. The expenses may include co-payments, hospital charges, laboratory charges and/or physician professional fees. We (I) hereby authorize the Massachusetts General Hospital Fertility Center to release such information from our (my) medical records as may be necessary for the settlement of all claims for payment of hospital charges.

We (I) understand the risks, benefits, and responsibilities as outlined, and further understand and agree that the Massachusetts General Hospital Fertility Center shall be responsible only for acts of negligence on its part and the part of its employees, contractors, consultants and authorized agents. We (I) have had the opportunity to review this treatment and ask questions of our (my) physician concerning alternative options to Therapeutic Donor Insemination, including adoption and no treatment, in an effort to help us overcome our (my) infertility. The nature of Therapeutic Donor Insemination has been explained to us (me), together with the known risks. We (I) understand the explanation that has been given to us. We (I) have had the opportunity to ask any questions we (I) might have and those questions have been answered to our (my) satisfaction. We acknowledge that Therapeutic Donor Insemination is being performed at our (my) request and with our (my) consent. We (I) understand, agree and acknowledge the terms of this document and attest that we (I) are (am) not married to individuals who are not parties to this agreement and informed consent.

Signature of Patient _____ Date _____

Signature of Husband/Partner _____ Date _____