Department of Obstetrics and Gynecology
Strong Fertility Center

Kathleen Hoeger, MD, MPH, Director
Snigdha Alur-Gupta, MD
Erin Masaba, MD
John T. Queenan, Jr., MD
Wendy Vitek, MD

EMBRYO THAW CONSENT

I/We _____ (patient)

and _____ (partner)
wish to have some/all of our cryopreserved (frozen) embryos thawed. Some or all of our embryos may not survive the thawing process. The determination of embryo viability after thawing will be made by the IVF laboratory. Information regarding the long-term effects of cryopreservation of the resulting children is not available, but information to date does not indicate any increase in birth defects or other problems. Equipment malfunction or technical error may occur and result in embryo loss.

Please check plan below for lab to Thaw accordingly:

☐ **Plan to Thaw & Transfer: Number of embryos to be thawed _____**
Number of embryos to be transferred _____
Special Comments if needed: _____
For PGT tested embryos only: Gender Preference- **YES**☐or **NO**☐
If yes, please indicate preference _____

☐ **Plan to Thaw and Biopsy for genetic testing (PGT-A/PGT-M):**
Number of embryos to be thawed _____
Special Comments if needed: _____

☐ **Plan to Thaw and Rebiopsy for genetic testing (PGT-A/PGT-M):**
Number of embryos to be thawed _____
Special Comments if needed: _____

I/We acknowledge that we have had an opportunity to ask questions and have had them answered to our satisfaction.

X_____ _____
Patient Signature **Date**

_____ _____
Patient Name **Date of Birth**

X_____ _____
Partner Signature **Date**

_____ _____
Partner Name **Date of Birth**

Notary Public **Date _____**

Witness in Office _____ _____