Request to Receive Cryopreserved Embryos *(from another clinic to FRMC)*

Fertility and Reproductive Medicine Center (FRMC) - Andrology Laboratory
Washington University Physicians and Barnes-Jewish Hospital

We, _____(DOB: _____)& _____ (DOB: _____) request that The Fertility and Reproductive Medicine Center (FRMC) at Washington University and Barnes-Jewish Hospital accept _____ vials/straws of cryopreserved embryos that are currently stored at the _____ laboratory.

Our physician has verbally informed us about the transfer procedure, and we have had a chance to ask questions and have voluntarily decided to consent to the transfer of our cryopreserved embryos to the Fertility and Reproductive Medicine Center at Washington University.

We acknowledge and agree that we have been informed of all known or potential risks, discomforts, and hazards associated with the transfer of embryos between laboratories. We have had the opportunity to obtain answers to all of our questions concerning the nature of the procedure, the alternatives, if any, and potential risks, discomforts, and hazards of the procedure.

We assume all of the risks of this transfer and hereby release and discharge Washington University, Barnes-Jewish Hospital, The Fertility and Reproductive Medicine Center, its employees and agents, our physicians, and such assistants as s/he may utilize from any and all causes, damages or injuries associated with or arising in connection with this procedure. We further agree that Washington University, Barnes-Jewish Hospital, The Fertility and Reproductive Medicine Center, its employees and agents, our physicians and such assistants as s/he may utilize shall have no legal or financial obligations or responsibilities of any type that arise or result from our request to transfer cryopreserved embryos to The Fertility and Reproductive Medicine Center at Washington University.

We understand that a storage fee will be billed to us each year and that this fee may change at any time. The IVF program will not store embryos if the storage fee is not paid and the embryos will be discarded. We understand that it is our responsibility to notify the IVF Program if we change our mailing address. If the IVF Program cannot locate us, we understand and consent to the discarding of our embryos by the IVF Program.

We understand that the program is required to submit IVF data to a federal agency and there is a small chance that we will be contacted by the federal agency for follow up. Otherwise, we understand that our records will be maintained confidentially to the same extent as are any other medical records. We have been made aware of the costs and understand that we are financially responsible for any medical costs incurred by us, which are not covered by insurance carriers.

We agree to allow the FRMC to contact the transferring laboratory (please fill out page 2) to arrange the transfer of our embryos and for the FRMC to request and receive any of our personal information that is needed for the transfer of our embryos. This includes, but is not limited to, our sexually transmitted disease laboratory results performed at the time the embryos were cryopreserved.

Patient Signature	Date
Patient Signature (if applicable)	Date
Non-Family Member Signature	Date

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Information on Laboratory from which embryos will be received (to be filled out by patient)

Name of Contact Physician: _____

Name of Laboratory: _____

Name of Laboratory Director or Contact Person: _____

Mailing Address of Laboratory: _____

_____

Phone Number: _____ Fax Number: _____

_____
Email address (if available)

Patient Contact Information

Patient Mailing Address: _____

_____

Patient Phone Numbers: _____ _____