Massachusetts Department of Public Health
Informed Consent Form for Infertility Treatment Involving Egg Retrieval

Facility Name: _____

Patient Name: _____

Patient I.D. Number: _____

The Undersigned Patient:

(1) Has been given and has reviewed and understands the informational pamphlet entitled "Egg Retrieval" distributed by the Massachusetts Department of Public Health;

(2) Has consulted with her physician or health care provider concerning the general procedures involved with egg retrieval and her specific medical situation;

(3) Has received and read the Consent to Treatment/Informed Consent Form (Health Care Provider Informed Consent Form) provided by the physician or health care provider which explains the procedure, and process and risks involved with egg retrieval. (A copy of the Health Care Provider Informed Consent Form is attached to this document);

(4) Understands the procedure, process and risks as explained in the Egg Retrieval pamphlet and the Health Care Provider Informed Consent Form;

(5) Consents to proceed with the procedure or process described in the Health Care Provider Informed Consent Form.

Notes: This section shall be completed by the physician or health care provider and shall contain any medical information, alternative procedures, medicines, devices, considerations or risks relevant to the specific patient's informed consent to proceed. Additional pages should be used if necessary.

Print Patient's Name: _____

Patient's Signature: _____ **Date** _____

Print Physician/Health Care Provider's Name: _____

Physician/Health Care Provider's Signature: _____ **Date**_____

A physician or other health care provider treating a woman by a procedure by which an egg is intended to be retrieved shall provide the patient with this form or a legible copy thereof, and shall keep a signed copy of this document in the patient's file.