IVF SYD
Fertilitetsklinik

STATEMENT OF CONSENT
IVF TREATMENT USING DONOR SPERM

The undersigned hereby requests Fertility Clinic IVF-SYD that IVF treatment be performed using donor sperm in the treatment of my/our infertility. I/we confirm to have received thorough verbal and written information about all the details of IVF treatment, as well as the side effects and risks (bleeding, infection and ovarian hyperstimulation syndrome) that may be associated with the treatment. I am/we are also informed about the very small risk of blood clots in connection with hormone treatment.
Furthermore, I/we have been informed about the various contracts (single treatment, package solution with 3 treatments and "baby or money back" guarantee) that are offered at Fertility Clinic IVF-SYD.

If I/we have chosen anonymous donor sperm, I/we agree that the donor's anonymity is preserved, and that the choice of donor is left to the fertility clinic.

I am/we are informed and consent that;

1) it is not possible to test a sperm donor for all genetic diseases, and that it is important that I/we contact Fertility Clinic IVF-SYD if a child is born with, or later develops, a condition that can be related to the donor. This also applies if the sperm was not purchased from IVF-SYD

2) Fertility Clinic IVF-SYD cannot be held responsible for results or consequences of treatment beyond what may result from the Danish law on doctors' responsibility for errors and omissions

Furthermore, we are aware that later on information about hereditary disease in the donor may appear. This may emerge many years after the donation, as some inherited diseases only show up late in life. If my/our treatment using donor sperm results in the birth of a child and such information emerges, I/we will be notified until the child's 18th birthday. After the child's 18th birthday, he/she may be notified directly.

If there is a partner:
I (partner) give my consent to the IVF treatment of my spouse/partner using donor sperm. The treatment will be performed by a doctor or under a doctor's responsibility and I will take full parental obligation of the child/children born due to this treatment.

If there are fertilized eggs available for freezing, I/we want these:

☐ **Destroyed**

☐ **Frozen**

If I/we want surplus fertilized eggs (embryos) frozen, I/we agree that:

1) According to Danish law, the embryos should be discarded when the woman receiving the eggs reaches the age of 46. This will happen without further notice.
2) It is my/our responsibility to always keep the contact information up to date at the Fertility Clinic IVF-SYD, so that it is always possible to contact me/us and send an invoice for the storage to the correct address.
3) There is an annual fee for storing frozen eggs, according to the current price list. The fee is to be prepaid annually following an invoice sent by the fertility clinic. However, the first year of storage is free of charge. If I/we do not pay the storage fee, Fertility Clinic IVF-SYD is entitled to discard the embryos.
4) If the treated woman from whom the eggs origin dies, the embryos must be discarded. This does not apply to donated eggs.
5) Loss or damage of embryos is not compensated in the event of unforeseen events (force majeure). Loss or damage of embryos due to other conditions is only reimbursed with an amount corresponding to the remaining paid storage period. Fertility Clinic IVF-SYD cannot be held liable for any direct or indirect loss.
6) If I/we want the embryos destroyed or transferred to another storage location, I/we must give Fertility Clinic IVF-SYD written consent to this. We will take care of the transport ourselves.

If the embryos have emerged using sperm from a donor, the Danish law states that:

1) The embryos may only be thawed and utilized, provided the patient has given written consent to this before each treatment. If there is a partner, they should both sign the consent.
2) In the event of the death of the partner, separation, divorce, or the termination of cohabitation the frozen embryos can still be utilized by the patient (signatory to this consent), given the partner gives his/her written consent to this.

If the partner in the relationship dies, we want;

☐ **the fertilized egg(s) to be destroyed**

☐ **the patient (signatory to this consent) can utilize the egg(s)**

☐ **Other: _____**

I/we confirm that I am/we are informed that severe obesity can lead to serious risks of complications in connection to a pregnancy for both mother and child. Therefore, Fertility Clinic IVF-SYD does not offer treatment if the woman's BMI is 35 or above.

The Danish law states that the clinic must have a contract with another tissue center in case Fertility Clinic IVF-SYD should close. Fertility Clinic IVF-SYD has contracted with Maigaard Fertility Clinic in Aarhus, Denmark, so that frozen embryos/eggs/spermatozoa and all proper documentation in connection with the treatment will be transferred to them.

If the treatment should lead to a viable pregnancy, I/we are obliged to report back to Fertility Clinic IVF-SYD about the birth and inform about the child/children born. The form to be completed is available on the clinic's website.

_____
Date

_____
Woman's date of birth

_____
Partner's date of birth

_____
Woman's name (capital letters)

_____
Partner's name (capital letters)

_____
Woman's signature

_____
Partner's signature

_____
Signature of the witness/doctor