



Pre-Implantation Genetic Screening (PGT-A) Consent Form

Patient's surname:

Patient's first name(s):

Date of Birth: **Patient Number:**

Partner's surname:

Partner's first names:

Date of Birth: **Patient Number:**

We have read and understood the contents of the PGT-A information sheet. We understand that Preimplantation Genetic Screening (PGT-A) has benefits and risks, some of which may be unknown at this time. We wish to proceed with PGT-A for aneuploidy using NGS analysis of cells biopsied from our embryos and consent to the procedures necessary for PGT-A.

I/we understand that:

- a) Removal (biopsy) of cells from suitable embryos will take place either 0-1, 3 or 5-6 days after insemination.
- b) The biopsied cells will only be tested for chromosomal abnormalities.
- c) The testing will be performed at an approved diagnostic laboratory working together with FGA.
- d) The diagnosis may show that all the embryos have chromosomal abnormalities.
- e) Not all embryos biopsied may yield a result (Genesis Genetics 2014 rates show 3.8% of embryos did not yield a result).
- f) There may be no suitable embryos for transfer.

- g) I/We understand that under no circumstances will an embryo showing an abnormal result be transferred into the uterus.
- h) The transfer of chromosomally normal embryo(s) does not eliminate the chances of miscarriage or guarantee the birth of a healthy baby.
- i) I/We must not have unprotected sex during the PGT-A cycle.
- j) There is a small risk (1-2%) of misdiagnosis (Gutierrez-Mateo 2011, Mir 2013, Wilton 2009).

After the embryo transfer, I/we wish any remaining chromosomally normal embryos to be **(please delete as appropriate):**

- a) Cryopreserved for future use
- b) Used for training purposes (see specific patient information sheets and training consents if applicable)
- c) Discarded

After the embryo transfer, I/we wish any remaining chromosomally abnormal embryos to be (please delete as appropriate):

- a) Used for training purposes (see specific patient information sheets and training consents if applicable)
- b) Discarded

We have been given an opportunity to ask questions about the PGT-A procedure and the contents of this consent form. If we think of additional questions, we may contact our Clinician, genetic counsellor, or embryologist.

I/We acknowledge that the FGA's general Patient Terms & Conditions will apply to the services provided in connection with this form and additional consents for IVF will apply.

Patient name: **Patient signature:** **Date:**

Partner's name: **Partner's signature:** **Date:**

Staff name: **Staff signature:** **Date:**