Pre-Implantation Genetic Diagnosis (PGT-M/SR) 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 fully understand the contents of the PGT-M/SR patient information sheet and confirm that we have had the opportunity to ask questions and discuss the procedure and we have received satisfactory answers from members of the medical and scientific staff of FGA. We have been offered suitable opportunity to receive implications counselling. If we think of additional questions, we may contact our Clinician, genetic counsellor or nurse.

We understand that Pre-implantation Genetic Screening has benefits and risks, some of which may be unknown at this time. We wish to proceed with PGT-M/SR for genetic diagnosis of cells biopsied from our embryos.

We also understand that undergoing PGT-M/SR does not eliminate the need for standard prenatal testing such as chorionic villous sampling or amniocentesis. The need for these tests remains the same whether or not PGT-M/SR is performed. We understand that if we have questions about CVS or amniocentesis we may ask our obstetrician or we may request a referral to a specialist Genetic Counsellor.

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.

I/we understand that:

1. Removal (biopsy) of 1 or 2 cells from suitable embryos will take place approximately 3 days after insemination.

2. The biopsied cells will only be tested for the specific mutations.
3. When testing for chromosomal abnormalities, the unaffected embryo can be either chromosomally normal or chromosomally balanced.
4. When testing for recessive single gene disorders, the unaffected embryo can be either normal or a carrier of the defective gene.
5. The testing will be performed at an approved diagnostic laboratory working together with FGA
6. The diagnosis may show that all the embryos are abnormal ('affected embryos').
7. I/we must not have unprotected sex during the PGT-M/SR cycle.
8. There is a risk of misdiagnosis.

Please delete as appropriate:

1. After the embryo transfer, we wish any remaining unaffected embryos to be:
    a. Cryopreserved for future use
    b. Used for training purposes (see specific patient information sheets and training consents if applicable)
    c. Discarded
2. After the embryo transfer, I/we wish any remaining affected embryos to be:
    a. Used for training purposes (see specific patient information sheets and training consents if applicable)
    b. Discarded

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:**