Consent to assisted reproduction

Woman's name and personal number (11 numbers)	Partner's name and personal number (11 numbers)

By signing this form we declare that we are either married or cohabiting in a marriage-like relationship.
Our consent is voluntary and is based on detailed and exhaustive information.

We understand that we can withdraw the consent in writing before treatments begin. We are responsible to make the attending physician aware that the consent has been withdrawn.

We are informed that the treatment can cause complications including, but not limited to, overstimulation, infection, bleeding and ectopic pregnancies. If and when several embryos are placed back the treatment can also increase the risk of multiple pregnancy.

We consent to the treatment being carried out in accordance with national laws and the department's current clinical and laboratory routines.

We consent to surplus oocytes or embryos being frozen for future use according to the department's current criteria.
Only oocytes or embryos of sufficiently good quality would be frozen.

We are informed about and accept the risks of
damage to oocytes and embryos during freezing procedures or in storage despite normal safety routines.

We are informed that surplus embryos are stored for up to 10 years from the date of freezing, but a maximum of until the woman turns 46 years old. At the age of 46, the embryos will be destroyed without further advance notification.
We are informed that if we got separated or divorced during treatment or during the storage period of frozen embryos, the embryos must be destroyed.

If the woman's partner dies, stored embryos can be used by the surviving spouse or cohabitant before she turns 46, but only if it can be documented that this is was line with the wishes of the deceased partner and provided that all additional legal conditions are met, including, but not limited to, medical and parental fitness. If the woman dies, the embryos must be destroyed.

We are informed that up to three treatment attempts with fresh embryo transfer could be offered. The treatment may be discontinued if medical or other conditions warrant.

Yes ☐ **No** ☐ - We agree that sperm samples, surplus unfertilized oocytes or embryos, **which cannot be used in treatment and would be otherwise discarded**, can be used for staff training and quality assurance. Only anonymous use of material is allowed.

Yes ☐ **No** ☐ - We authorize the Department of Reproductive Medicine to obtain information about treatment outcome and the health of the mother and the newborn(s) from the maternity ward after birth.

Yes ☐ **No** ☐ - We authorize the Department of Reproductive Medicine to report treatment outcome to the Medical Birth Registry of Norway.

Date _____ Woman's signature _____

Date _____ Partner's signature _____

I have received the consent form and verified the couple's identity.

Date _____ Health worker's signature _____