Main Line Fertility Center
Embryo Biopsy for Preimplantation Genetic Testing (PGT)
Informed Consent Form

PURPOSE

The purpose of this form is to obtain your consent to **biopsy** (remove cells) from embryo/s for preimplantation genetic testing (PGT).

BIOPSY AND ANALYSIS

Preimplantation genetic testing requires the embryologists to remove a small number of cells from the embryo in a process known as embryo biopsy. Cells are removed from the outer layer of the blastocyst embryo (trophectoderm). Embryo biopsy is performed on day 5, 6, or 7 of embryo development. The cell sample from biopsy will be sent for analysis to the designated reference laboratory established before retrieval. The blastocyst embryo will remain in culture or be frozen at Main Line Fertility Center.

A percentage of your embryos should develop to the blastocyst stage. However, not all of your embryos will develop into a blastocyst, and it is possible you will not have any blastocysts to biopsy. Embryos not developing to the blastocyst stage will not be tested and will be discarded.

In most cases, blastocysts will be cryopreserved (frozen) after biopsy. Once the genetic testing results are obtained, the embryos reported as normal will be considered for transfer. This embryo transfer will occur in a future cycle as results may take at least two weeks to be reported.

In special circumstances, a physician may order rush PGT so your results will be available within 24 hours of biopsy. In this case, your embryos will be cultured after biopsy and results will be available within 24 hours for possible transfer the next day.

RISKS AND LIMITATIONS

The following risks and limitations are associated with biopsy for PGT; however additional risks may exist.

1. Although rare, it is possible that some or all embryo(s) may be damaged during biopsy. The risk of damage to the embryo is related to embryo quality, thus only good quality blastocysts will be biopsied.

2. It is possible that one or more of your cell samples may not amplify and a reading will not be obtained. In this instance re-biopsy is recommended before transfer.

3. It is possible that all cell samples tested will be reported as abnormal, and therefore no embryo will be eligible for transfer.

4. The transfer of a PGT tested embryo does not guarantee pregnancy or normal baby.

5. Prenatal testing such as chorionic villus sampling, amniocentesis, ultrasound and bloodwork post-IVF is strongly recommended.

ALTERNATIVES

PGT is not a requirement for your IVF cycle. Your MLF physician and you will decide if PGT may be beneficial based on your medical history and personal preferences. Standard prenatal testing for abnormalities is strongly recommended after pregnancy is established. This includes chorionic villous sampling (CVS), amniocentesis, and ultrasound examination of the fetus.

CONSENT TO DISCARD OR STORE EMBRYOS THAT HAVE BEEN REPORTED TO BE ABNORMAL

I/We understand that by consenting to PGT that some or all of my/our embryos may be reported to be chromosomally or genetically abnormal.

- Embryos reported as abnormal **cannot be transferred to attempt pregnancy at the Main Line Fertility Center**. You may transport them to another fertility center.
- If you choose to keep embryos reported as abnormal in cryostorage, you will be financially responsible for their storage fees.

Please initial one of the following options:

1. Discard embryos reported as abnormal ____/____
2. Do NOT discard embryos reported as abnormal. ____/____

CONSENT TO BIOPSY EMBRYOS FOR PGT

I/We have been given the opportunity to ask questions about biopsy for PGT and the contents of this consent form. I/We understand the benefits and risks associated with biopsy for PGT and hereby give consent to biopsy embryos for PGT at Main Line Fertility Center.

If you have any questions, please contact the PGT coordinators:

Jennifer Jones at 484-380-4870 or jennifer.jones@mainlinefertility.com
Beth Raneiro at 484-380-4871 or beth.raneiro@mainlinefertility.com
Sharon Anderson, PhD at 484-380-4884 or sharon.anderson@mainlinefertility.com

I acknowledge that I have read and understood the information provided regarding biopsy, PGT, and their risks, and I agree and consent to biopsy for PGT at the Main Line Fertility Center as my signature below testifies:

X _____ _____

Patient Signature Date

_____ _____

Patient Name Date of Birth

Notary Public
Sworn and subscribed before me on this _____ day of _____, _____.

_____ _____

Notary Signature Date

X _____ _____

Spouse / Partner Signature Date

_____ _____

Spouse / Partner Name Date of Birth

Notary Public
Sworn and subscribed before me on this _____ day of _____, _____.

_____ _____

Notary Signature Date

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If signed in the office:

Statement by Witness (must be employee of Clinic and at least 18 years of age)

I declare that the person(s) who signed this document is/are personally known to me and appear(s) to be of sound mind and acting on their own free will. They signed this document in my presence.
_____ Photo ID checked by _____
_____Form of photo ID: (circle one) Valid Driver's License/Passport/Other _____

	Patient	**Partner**
Witness Name:	_____	_____
Witness Signature:	_____	_____
Date:	_____	_____