MAYOR'S IVF

(A Unit of Mayors Eye Clinic & Fertility Centre)

ID :		**G :**	**Live :**	**Sab :**	**Tac :**
Name :		**Procedure :**		**Diagnosis**	
Age :		**Protocol :**		**Cycle**	
PHONE:		**LMP :**		**Of Prior IVF**	

YEAR		**MEDICATIONS**			**RO**	**LO**	**ENDO**
DATE	**CD**	**AG/ANI**	**HMG**	**FSH**			

RETRIEVAL DATE: **RETRIEVAL MD:** **O OOCYTES:** **NORMAL FORTE:** **ET DATE:** **ET MD:**	**FROZEN:** **OUTCOME : CONC/+/** **HCG TITRE:** **DATE:** **FUTURE PLAN:** **SIGNATURE:**	**REMARKS:** **SPECIAL INVESTIGATIONS:**

MAYOR'S IVF

(A Unit of Mayors Eye Clinic & Fertility Centre)

ID :		**G:**	**LIVE :**	**TAB :**	**ECT :**
NAME :		**PROCEDURE :**		**DIAGNOSIS :**	
AGE :		**PROTOCOL :**		**CYCLE :**	
PHONE:		**LMP :**		**OF PRIOR IVF:**	

YEAR		**MEDICATIONS**			**RO**	**LO**	**ENDO**
DATE	**CD**	**AG/ANI**	**HMG**	**FSH**			

RETRIEVAL DATE: **RETRIEVAL MD:** **O OOCYTES:** **NORMAL FORTE:** **ET DATE:** **ET MD:**	**FROZEN:** **OUTCOME : CONC/+/** **HCG TITRE:** **DATE:** **FUTURE PLAN:** **SIGNATURE:**	**REMARKS:** **SPECIAL INVESTIGATIONS:**

MAYOR'S IVF

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HISTORY SHEET

Name of the Patient : ……

Age :……. Wife…..……Husband…….....Refferred by ……

Address : ……

Telephone No : ……..Res: ……Office/Mobile ……

HISTORY

Infertility ……. Primary/Secondary ……

Duration ……Year ……

Obst. History ……

Menstrual History ……..LMP……

Past History / Medical History ……

History of Surgery ……

Past Infertility Treastment ……

O/I ……. Time ……..Stimulation with ……

IUI ……. Cycles at ……

IVF ……. Cycles at ……

Protocol Used

Eggs Recovered = Eggs Fertilized= Transferred=

Outcome

EXAMINATION

P ……BP……..RS/CVS……P/A……..

P/S……P/V……

INVESTIGATIONS

HIV 1 & 2 ……HBsAg…….. CBC …….. ESR……..
VDRL ……Blood Sugar…….BL.GR & RH……BT…….
CT ……Toxo…….. PTT …….. CMV……..
Rubella ……..……Herpes…….. Chlamydi…….. Anti HCV……..
Urine- R/M ……..…E2…….. P2 …….. Urea……..
Creatinine ……..…LFT…….. K…….. Cl…….
Na……..…….. HbA1C ……..

HORMONE ASSAY

AMH ……FSH…….. LH …….. TSH……
T3……..……T4……..Progestone……..…Prolactin……
Testosterone……Insulin…….……..

RADIOLOGICAL STUDY

X-Ray Chest ……ECG…….. USG …….. MRI Scan……
CT Scan……..……

HISTOPATHOLOGICAL STUDY

ENDOMETRIAL BIOPSY…….TB PCR……..……..

HYSTEROSALPINGOGRAM	HYSTEROSCOPY	LAPROSCOPY

HUSBAND SEMEN ANALYSIS

DATE	VOL	COUNT	MOTILITY	GRADE	ABNORMALITY

SEMEN CULTURE

NO.	DATE	FINDINGS

Scrotal USG ……

Testicular Biopsy ……..

Blood Sugar	**HIV 1 &2**	**FSH**
HbA1C	**Hbs Ag**	**LH**
ABO & Rh FACTOR	**VDRL**	**Testosterone**
	Anti HCV	**Prolectin**

PLAN OF ACTION

MAYORS IVF

(a Unit of Mayors Eye Clinic & Fertility Centre)

MAYOR'S IVF

(A Unit of Mayors Eye Clinic & Fertility Centre)

FORM 6

Consent Form to be Signed by the Couple or Woman

I/We have requested the clinic…….
……. (name and address of clinic) to provide us with treatment services to help us bear a child.

1. The drugs that are used to stimulate the ovaries for ovulation induction have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.
2. There is no guarantee that:
   (i) The oocytes will be retrieved in all cases.
   (ii) The oocytes will be fertilized.
   (iii) Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.All these unforeseen situations will result in the cancellation of any treatment.
3. I/ We fully consent to these procedures and to the administration of such drugs and anesthetics as may be necessary. We also consent to any other operative measures, which may be found to be necessary in the course of the treatment.
4. I/ We have been told of the risks of ultrasound directed follicle aspiration.
5. I/ We are aware that we are free to withdraw or vary the terms of this consent until the gametes and/ or embryos have been used in accordance with my/ our wishes. I am aware that this will have to be a written request
6. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are transferred.
7. If a clinical pregnancy does result from assisted conception treatment, I/ we understand there is an accepted risk of multiple pregnancy, an ectopic pregnancy or of a miscarriage. I/ We understand that as in natural conception, there is a small risk of fetal abnormality.
8. Medical and scientific staff can give no assurance that any pregnancy will result in the

delivery of a normalliving child.

9. The uncertainty of the outcome of the procedure has been fully explained to me/ us.

I/ We fully understand the risks of treatment including;

(i) it is not possible to guarantee that a follicle will develop in a given cycle and that occasionally cycles have to be abandoned before egg retrieval.

(i) there is a risk that spontaneous ovulation can happen prior to/or during the egg retrieval.

(ii) an egg is not always recovered from a follicle at the time of egg retrieval.

(iii) any eggs may be collected and fertilization of any collected eggs will occur

(iv) is a risk that the cycle will be abandoned before Embryo Transfer if there is failure of fertilization,abnormal fertilization or failure of the embryo to cleave(divide)

(v) a pregnancy may result from treatment.

(vi) treatment may be abandoned at any time if there are problems in the laboratory or with the culturesystem

10. I/ We have been fully informed of all that is involved with the IVF/ICSI technique and have been advised regarding the chances of success, the possibility of multiple pregnancy occurring and other possible complications of treatment by the doctor. I/ We have also received information relating to treatment by these techniques in order to assist us to become more fully aware of what is involved.

Endorsement by the ART clinic

I/we have personally explained

to_____ and

_____ the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he /she /they understand these details and implications.

This consent would hold good for all the cycles performed at the

clinic.

Name and Signature of the couple (husband and wife) or Woman

Name, Address &Signature of the Witness from the Clinic

Name and Signature of the Doctor

Name and Address of the ART Clinic

Dated: ……

FORM -7

Consent for IUI with Husband's Semen/ Sperm

We,_____and_____,

being husband and wife and both of legal age, authorize Dr _____.____to inseminate the wife intrauterine with the semen / sperm of the husband

for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

The procedure carried out does not ensure a positive result, nor does it guarantee a mentally and physically normalchild. This consent holds good for all the cycles performed at the clinic.

Signature of intending couple

Husband :

Wife:

Endorsement by the ART Clinic

I / we have personally explained to …… and.....the details and implications of his /her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / theyunderstand these details and implications.

Name, Address and Signature of

the Witness from the clinic

Signed_____ (Husband)

_____ (Wife)

Name and Signature of the Doctor

Name and Address of the ART clinic

Dated:

FORM 12
Consent for Oocyte Retrieval

Name(s) and address(es) of patient

Name and address of the Clinic:

I have asked the Clinic named above to provide me with treatment services to help me bear a child.
I consen

1. Being prepared for oocyte retrieval by the administration of hormones and other drugs
2. The removal of oocytes from my ovaries under ultrasound guidance / laparoscopy

I/We had a full discussion with …….. about the above procedures and the risks and complications involved and I have been given oral and written information about them I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

I/We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I/We have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general / regional / sedation) has been discussed in terms which I have understood.

Signature of intending couple/ intending woman

Endorsement by the ART Clinic

I / we have personally explained to ……..…. and ……..….. the details and implications of her signing this consent / approval form, and made sure to the extent humanly possible that she understands these details and implications.

Signature of woman

Name, address and signature

Name, address and signature of the Witness from the clinic

Name and signature of the Doctor

Consent of Husband (as and if applicable)

As the husband/partner, I consent to the course of the treatment outlined above. I understand that I will become the legal parent of any resulting child, and that the child will have all the normal legal rights on me.

Name, address and signature: _____ (Husband)

Name, address and signature

of the Witness from the clinic: _____

Name and signature of the Doctor: _____

Dated

FORM 10

Consent for Freezing of Gametes/Sperm/Oocytes

I/We, …… and ....., consent to freezing of the my .....(sperm/oocyte). We understand that the gametes would be normally kept frozen for ten years. In the exceptional circumstances If I/we wish to extend this period, we would let the ART clinic ……..(Name and address) know at least six months ahead of time. If you do not hear fromus before that time, you will be free to (a) use them for research purposes; or (b) discard and destroy them off. We also understand that sometimes the quality of these sperm/occytes may decrease on subsequent thaw and that frozen gametes may have a lower pregnancy rate than when fresh gametes are transferred.

***Husband / Man**

In the unforeseen event of my death, I would like the gametes

To perish ☐

To be handed over to my wife/ ..... (specify name and details) ☐

Used for research purposes ☐

Signed: Dated:

***Wife / Woman**

In the unforeseen event of my death, I would like the gametes ☐

To perish

To be handed over to my husband/ …… ☐

……(specify name and details)

Used for research purposes

☐

Signed: Dated:

Name, Address and Signature of the couple/woman/man

Endorsement by the ART clinic

I/ we have personally explained to ……..…….…… and …….. the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

Name, Address and Signature of the Witness from the Clinic

Name and Signature of the Doctor

Name and Address of the ART Clinic

*The appropriate option may be ticked

Date: ……

Place: ……

Terms and Conditions

Provision of Information

As long as I have cryopreserved gametes in storage at clinic mentioned above, I hereby agree to contact the above clinic at least annually to provide current information indicating my address, telephone number, email address and contact details and intention regarding my cryopreserved gametes.

Failure to:
contact the clinic for a period of twelve months;

respond to a request for information from clinic within 90 days of receipt; shall constitute abandonment and signify my desire to terminate storage of Cryopreserved gametes.

In the event of my failure to comply with (i) and (ii) above, I instruct the above-mentioned clinic and hereby consent to my Cryopreserved gametes either being destroyed and discarded or given for research.

Payment of Fees

I understand that I am responsible for the costs of cryopreservation and storage of my Cryopreserved gametes. Cryopreservation and storage fees are due and payable at the time of gamete cryopreservation, and at the beginning of each annual storage interval thereafter. I understand these fees are non-refundable and are not subject to prorated adjustment for partial storage intervals. Should the yearly fee for storage of my Cryopreserved gametes, remain unpaid for a period of one year after the first invoice is forwarded to my address/email/informed to me telephonically the clinic can conclude that I am no longer interested in storing these specimen(s) and I hereby instruct the clinic to destroy of my Cryopreserved gametes or use for research.

Alternate Contact/Responsible Party

I hereby name …… as an alternate contact and my representative to assume responsibility for sections 1 and 2 above in the event that I am unable due to illness. I have attached a signed acknowledgement by that they have read this form and will be responsible for its provisions in the event that I cannot.

FORM 15

Consent Form for the Donor of Sperm

I, Mr. …….……Address……..…… …….. Mobile number……. AADHAR card number……. Willingly consent to donate my sperm to couple/individual who are unable to have a child by other means. At this stage and to the best of my knowledge I am free of any infectious diseases or genetic disorders

I have had a full discussion with Dr. …… (name and address of the clinician)
on..... ,
I have been counselled by …… (name and address of independent counsellor) on ……..

(I understand that there will be no direct or indirect contact between the recipient, and me, and my personal identitywill not be disclosed to the recipient or to the child born through the use of my gamete: If applicable)

I understand that I shall have no rights whatsoever on the resulting offspring and vice versa.

Signature of Donor

Endorsement by the ART bank

I/we have personally explained to.....the details and implications of his signing this consent / approval form, and made sure to the extent humanly possible that he understands these details andimplications.

Name and signature of the Doctor

Name, address and signature

of the Witness from the ART bank

Name and address of the ART bank Dated: ……

Consent form to be signed by the couple for IVF

We _____ & _____ have understood the entire procedure of the IVF. The cost involved on the procedures has been clearly explained to us and is acceptable to us. This cost is non – refundable under any circumstances. We have been told that the average success rate of IVF is 35%-40% and the same hold true in our case. We have also been explained that no sex separation, choice of a particular sex or sex identification will be done at Mayor's IVF (A Unit of Mayors Eye Clinic & Fertility Centre). The information that I have given to my doctors regarding my history and treatment done preciously are true to my knowledge.

All my reports and prescription have been handed over to me during the course of treatment.

Signed : …….(Husband)

…….(Wife)

Consent For Surgery (Oocyte Retrieval /Embryo Transfer)

My treating IVF Specialist, so named on the first page of this consent form, has Explained the risks to us verbally and I have been given information about this treatment .

A. Ovum pickup procedure which describes the likelihood of possible risks, complication and unwanted effect such as

1.Ovarian hyperstimulation and it's Complications.

2. Risk of ovarian damage or torsion which may result in loss of ovarian tissue.

B. In relation to embryo transfer, it is important to note that:

1. The transfer of single embryo could result in no live birth, a singleton birth, And

2. The transfer of two embryo could result in no live birth, A singleton Birth, Twins

3. Miscarriage

4. Ectopic pregnancy

I have had the opportunity to discuss the treatment and procedure and any possible Problems arising from it,with my IVF Specialist.

I understand that complications may occur with any operations/ procedure and I accept the possible risks associated with this operation/procedure such as, but not limited to, bleeding , infection and damage to other internal organs, which may require further surgery and I/We request that this be carried out if required.

I Understand that such complications may result in long- term medical problems such as adhesions and loss of fertility and I accept these possible risks.

I Understand that even with this treatment and operations/ procedure being carried out with all due professional care and responsibility, that there is no gruarantee that this will result in a viable pregnancy. This may occur for several reasons, including but not lmited to:

Inability to achieve adequate stimulation of ovaries.

Inability to obtain eggs or sperm

Lack of fertilization of eggs.

Inadequate embryo development.

Failure of the embryo to survive the freeze/thaw process.

Failure of the embryo to implant in the uterus after transfer.

Miscarriage and ectopic pregnancy.

C. I understand that cancellations or abandonment of the treatment or procedure may be necessary at any stage.in circumstance where there is a risk that ovarian hyperstimulation may or does occur after 'egg pickup', it may be necessary to freeze all.

Signature Of Husband

Name,

Address &Signature of the

Witness From clinic

Signature Of Wife

Name and Signature of the Doctor

Date

Consent for the Procedure of PESA of TESA

Name of the female partner…….Name of the male partner……..

We hereby request and give consent to the procedure of PESA and TESA for ICSI , to be performed on the male partner.

We understand that

a) There is no guarantee that the Sperm will be successfully removed or that sperm will necessarily fertilizes our oocytes.

b) Should the sperm will retrieval fail, the following options will be available for the retrieved oocytes.

I. Insemination of all or some oocytes using donor sperm

II. Donation of oocytes to another infertile couple

III. Disposal of oocytes according to the ethical guidelines.

(Tick the appropriate option)

Each of the above points has been explained to us by_____

The procedure (s) carried out does (do) not ensure a positive result, nor do the clinic .

Endorsement by the ARTclinic

I/We have personally explained to _____and _____the details and Implication of his/her/their signing the consent/ approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature of the witness from the clinic

Name and Signature of the Doctor
Dated
*The appropriate option may be ticked

Endorsement by the ART clinic

I/We have personally explained to _____and _____

the details and Implication of his/her/their signing consent / approval form, and made sure to the extent humanly possible that he/ she/ they understand these details and implications.

Signature of Male Partner

Signature of Female Partner

Name and Signature of the Doctor

Dated

Name, Address and Signature of the Witness from the clinic. `

MAYOR'S IVF

(A Unit of Mayor's Eye Clinic & Fertility Centre)

Dr. Meetu Bhushan Mayor
M.B.B.S, MD (Gynae)

I, Ms ……..(Name of the Patient) declare that by undergoing intra uterine insemination / embryo transfer / ultra sonography / image scanning, I do not want to pre select (pre conception sex selection) to know the sex of my future child.

I…….. that while conducting intrauterine insemination / embryo transfer / ultra sonography / image scanning on Mrs, ……..
I have neither pre selected (pre conception sex selection); I neither detected nor disclosed sex of her future baby to anybody in my manner.

Date: ……l……..
Patient's Name: …… Signature : ……..
Husband's Name: …… Signature : ……..
Contact No.: ……
Witness: …… Signature : ……..
Time : ……

SELF DECLARATION FORM

I……W/O……..AGE…….declare that I have no history of any medical of surgical illness other than below mentioned conditions

- T.B / D.M / HYPERTENSION / THYROID
- ASTHMA
- MENTAL ILLNESS
- CARDIAC ILLNESS
- CHRONIC KIDNEY DISEASE
- ALLERGY
- SEIZURE
- Details of previous surgery if any ……..……..
- Any other medical problems……....
- PATIENT SIGNATURE…….
- DATE ……..

CONSENT FOR ANAESTHESIA

The type of anesthesia proposed (General / Regional) has been discussed in terms which I have understood. The risk and hazards have been explained to me. I give my consent for the above mentioned anaesthesia

Name …….

Sign …….

Witness from clinic …….

Doctor Signature … …….

CONSENT FOR ANAESTHESIA

The type of anesthesia proposed (General / Regional) has been discussed in terms which I have understood. The risk and hazards have been explained to me. I give my consent for the above mentioned anaesthesia

Name …….

Sign …….

Witness from clinic …….

Doctor Signature … …….

ANAESTHESIA NOTES

* Date :

* Patient Name :

* Husband/Wife Name :

* Procedure :

* Surgeon :

* Anesthetist :

* Anaesthesia Given:

* Pre Op.Vital

* Pulse :

* B.P :

* Respiration :

* Any Other :

*Intra Operative

*

*

*

*

*Post Operative Status

*

*

*

*

Anaesthetist Signature

ANAESTHESIA NOTES

* Date :

* Patient Name :

* Husband/Wife Name :

* Procedure :

* Surgeon :

* Anesthetist :

* Anaesthesia Given:

* Pre Op.Vital

* Pulse :

* B.P :

* Respiration :

* Any Other :

*Intra Operative

*

*

*

*

*Post Operative Status

*

*

*

*

Anaesthetist Signature

OPU DETAILS / EMBRYO TRANSFER SHEET

s. No.	Patient's & Husband Name	Date of Pick Up	No. of Oocytes	HAS Details	No. of Egg Fertilized	ET Date	Remaining Embryos

MAYOR'S IVF

4/62 Roop Nagar

(A Unit of Mayor's Eye Clinic & Fertility Centre) **Delhi 110007**

9717896366 / 8178899674

Name : **Receipt No. :**

Age / Sex : **UHID:**

Sample Date :

Print date :

Semen Analysis

GROSS EXAMINATION

Colour :

Appearance :

Reaction :

Volume :

Liqueaction Time :

MICROSCOPY

Sperm Count :

MOBILITY

Progression :

Non Progression :

Immotile :

MORPHOLOGY

Normal :

Abnormal :

MISCELLANEOUS

Pus Cells :

RBC :

Impression :

MAYOR'S IVF

4/62 Roop Nagar

(A Unit of Mayor's Eye Clinic & Fertility Centre) Delhi 110007

9717896366 / 8178899674

Name : **Receipt No. :**

Age / Sex : **UHID:**

Sample Date :

Print date :

Semen Analysis

GROSS EXAMINATION

Colour :

Appearance :

Reaction :

Volume :

Liqueaction Time :

MICROSCOPY

Sperm Count :

MOBILITY

Progression :

Non Progression :

Immotile :

MORPHOLOGY

Normal :

Abnormal :

MISCELLANEOUS

Pus Cells :

RBC :

Impression :

CERTIFICATE OF HOME COLLECTION SEMEN SAMPLE

FOR USE IN IVF / ICSI PROCEDURE

This to certify that semen sample provided by me is my own sample.

I an providing this semen sample after home collection and I am handing over to embryologist of MAYOR'S IVF (A Unit of Mayors Eye Clinic & Fertility Centre). This sample of mine will be used for IVF/ICSI procedure of me and my wife.

Name And Signature of Husband

Name And Signature of wife

Date

Time

At the time of Discharge

1. **Temperature**
2. **B.P**
3. **Pulse**
4. **Spo2**
5. **P.A.**
6. **Bleeding**
7. **Urine pass**

At the time of Discharge

1. **Temperature**
2. **B.P**
3. **Pulse**
4. **Spo2**
5. **P.A.**
6. **Bleeding**
7. **Urine pass**

INVESTIGATIONS

(Wife)

1. CBC
2. TSH
3. RBS
4. BT, CT
5. HIV
6. HBsAg
7. HCV
8. VDRL
9. AMH
10. LFT
11. BLOOD GROUP
12. SERUM UREA
13. SERUM CRETANINE
14. SERUM ELECTROLYTES (Na + , K=)
15. URINE ROUTINE & MICROSCOPY
16. CHEST X-RAY
17. ECG
18. USG WHOLE ABDOMEN & PELVIS

(Husband)

1. HSA
2. HIV
3. VDRL
4. HCV
5. HBsAg
6. BG

CHECK LIST

1. Flow Sheet
2. Prescription Sheet -1
3. History Sheet -1
4. Self Declaration Form -1
5. IVF Consent -1
6. Surgical Consent
7. Anaesthesia Consent -2
8. Anaesthesia Notes -2
9. Semen Report -2
10. Consent of home semen collection
11. E.T. Sheet -1
12. Post Operative Vitals –2
13. Wife reports
14. Husband Reports
15. USG Report
16. ECG Report
17. X-Ray Chest Report
18. Wife ID
19. Husband ID
20. If any other report required
21. TESA Consent
22. TESA report urologist
23. TESA report Embryologist
24. Physician/ surgeon fitness if required

MAYORS IVF

(A Unit of Mayors Eye Clinic & Fertility Centre)