



Name of the clinic-----

## **COVID-19 PANDEMIC – CONSENT TO START TREATMENT, DISCUSSION AND PATIENT AGREEMENT FOR UNDERGOING IVF/ICSI and/or ET**

### **Patient Details**

Name----- Husband's name -----

I/we confirm that I/we have been given and understood the information below and that I/we have also received and read the *patient information leaflet* for fertility treatment during the COVID19 pandemic.

1. **Patient questionnaire.** I/we have been informed of the COVID-19 triage questionnaire, what it is used for and that I/we have to answer it truthfully.
2. **Health screening.** I/we understand that COVID-19 screening is recommended and the results will determine if I/we can start/continue with our treatment and I/we confirm that
  - a. I/we understand the implications of these screening tests.
  - b. I we understand that I/we will be informed of any results and the possible repercussions this may have
  - c. I/we understand that COVID-19 screening will happen before and during my treatment as follows:
    - i. All patients (couples) starting ovarian stimulation, IVF/ICSI or embryo transfer cycles will have a Covid-19 test, on Day 2 scan. You are informed that the results take in 24-48 hours to come.
    - ii. Patients and their husband's having ovarian stimulation will have a Covid-19 throat and nasal swab PCR test 48 hours before anticipated trigger date. You are informed that results can take 24-48 hours. Depending on your PCR test result, you will be advised whether we can proceed with or cancel your egg collection. You will also be advised at that time about when you should administer your trigger injection.
    - iii. Depending on your PCR test result, patients and husbands having an Embryo transfer, throat and nasal covid-19 swabs will be done on day of scan when Day 0/start of progesterone is set. Depending on your test PCR result, you will be advised whether we can proceed with or cancel your embryo transfer until the review.
  - d. I/we understand that this may be updated from time to time as the local guidelines stipulate.



- e. I/we understand that the best available tests (RT-PCR) is not fool proof to suggest that one is free of COVID-19 infection.
  - f. I/We understand that the testing for COVID-19 may have cost implications. The extra cost of testing will be borne by me.
3. **Minimising risk of infection.**
- a. I/we have been informed and agree to sign and follow a 'code of conduct' for minimisation of the risk of infection through physical distancing, wearing face covering/mask when necessary, having video consultations whenever possible and frequent hand hygiene as advised by the government.
  - b. I/we agree to wear face masks at all times in the clinic, attending on staff during consultations, tests, scans and procedures. This is for minimizing the spread of infection.
4. **Self-isolation during treatment.**
- a. I/we have been informed of the benefit to self-isolate once my/our treatment commences in order to minimise the risk of infection, and therefore minimise the risk of treatment cancellation. This period of self-isolation may commence following my/our first pre-treatment screening by ----- (name of clinic) and will last for the duration of the treatment.
5. **Adaptation of services** at ----- clinic
- a. I/we have been informed and agree to accept the adaptation of services in order to minimise the risk of COVID-19 infection.
6. **Treatment Planning.**
- a. I/we have been informed and agree to follow the treatment plan suggested by the clinician/ doctors during the COVID-19 pandemic.
7. **Cancellation of procedure.**
- a. I/we understand that my procedure (egg collection, embryo transfer, IUI, egg freezing, sperm freezing, thaw and biopsy) may be cancelled/postponed at any point due to a potential or confirmed COVID-19 infection of either myself or/and my husband, or due to staff shortages because of COVID-19 isolation.
8. **Gametes and embryos.**
- a. I/we understand that there is limited information on the possibility of SARS-COV-2 virus transmission through the semen and follicular fluid and the potential the transmission of infection between embryo cultures in the incubator and between gametes/embryos in the liquid nitrogen storage tanks and that the risks to gamete/embryo survival or patient health are unknown.
9. **Cryopreservation.**



- a. I/we have been informed and agree to cryopreserve (freeze) all my gametes or/and embryos if I or my husband exhibit COVID-19 symptoms or/and test positive for COVID-19 after my egg collection. I/we therefore understand that my/our embryo transfer will be cancelled at that point and a future cycle will need to be planned which may have cost implications.

10. **Pregnancy.**

- a. I/we understand that should a pregnancy be established there are unknown risks relating to COVID-19 to the mother and the fetus (baby/babies).

11. **Counselling.** I/we have been given suitable opportunity to take part in supportive counselling before, during and after this treatment and understand the implications of the proposed treatment.

12. I/we understand that the staff at the clinic/ hospital is following all procedures and steps to prevent spread of COVID infection, however despite these efforts I/ we are liable to get infected from other sources. In such an eventuality, will not hold the clinic/hospital responsible for the same.

13. I/we have been given the time to consider the contents of this document and we have been given the opportunity to make further enquiries as we wish before signing.

Patient's name (print): .....

signature: .....

Date: ...../...../.....

Husband's name (print): .....

signature: .....

Date: ...../...../.....

Witness name (print): .....

signature: .....

Date: ...../...../.....

Statement of interpreter (where appropriate). I have interpreted the information above to the patient to the best of my ability and in a way in which believe she / he can understand.



Interpreter name (print): .....

signature: .....

Date: ...../...../.....