Consent for Special Procedures: Oocyte Retrieval

1. I _____ hereby consent and authorize the physician(s) and/or the physician's designee(s), as employees and/or agents of Regional One Health or UT Regional One Physicians, Inc. to perform the recommended procedure known as: Ultrasound-guided Oocyte Retrieval.
2. I acknowledge that the nature, purpose and risk/complications of the proposed procedure(s); alternative methods of medical treatment (including risks of such alternatives); and the prognosis if no treatment is received, have been fully explained to me.
3. I understand that in addition to the particular risks of this procedure, there are risks including, but not limited to, blood loss, brain and nerve damage (including paralysis, loss of function and coma), infection, cardiac arrest, and death, which are risks inherent in the performance of any procedure.
4. I understand that during the course of the procedure, conditions may become apparent that require the physician(s) or their designee(s) to perform additional procedures or a different procedure from that described above that they believe are medically necessary to achieve desired benefits or for my well-being. I authorize and request the physician(s) and/or their designee(s) as employees and/or agents of Regional One Health or UT Regional One Physicians, Inc. to perform whatever medical acts or additional procedures they, in the exercise of their sole professional judgement, deem reasonable and necessary, and I waive any obligation on their part to stop or delay the continuation of my procedure(s) in order to obtain additional consent.
5. I am aware the practice of medicine is not an exact science. I acknowledge that no guarantee or assurance has been made to me as to the result that may be obtained from any procedure or treatment.
6. For the purposes of advancing medical education, I consent to the admittance of observers' discussion of my procedures with others who may not be directly responsible for my care and to the videotaping, photographing or televising of my procedure, including appropriate portions of my body, provided my identity is not revealed.

   Decline observers/photographing in above section 6. Patient initials: _____
7. I have read (or had read to me), understand and agree to the statements set forth in this consent form. I have had enough opportunity to ask questions, and my questions have been answered to my satisfaction. I understand that I may ask more questions at any time.

_____ _____

Patient Signature /Patient's Representative Date Time

_____ _____

Patient or Patient Representative Printed Name Relationship of Representative to Patient

_____

Witness Signature

_____

Witness Printed Name

Physician Attestation

The above mentioned Patient and Partner (if applicable) have been informed and counseled by me and others regarding the risks and benefits of the relevant treatment options, including non-treatment. The Patient and Partner (if applicable) expressed understanding of the information presented during the discussion.

_____

Physician Signature Date

_____

Physician Printed Name

Affix Patient Label

Patient's Initials _____