

Female Patient Name:

SS# / Driver's License#:

New England Fertility Institute

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ULTRASOUND-GUIDED NEEDLE FOLLICULAR ASPIRATION **Description, Explanation and Informed Consent**

I hereby consent to undergo ultrasound-guided needle follicular aspiration for egg retrieval.

I understand this is done through the use of a vaginal ultrasound probe that has a special needle alongside the probe. This needle goes through the vaginal wall and aspirates the fluid from the follicles located in the ovary.

I understand there are possible risks associated with an ultrasound-guided needle aspiration procedure. The possible risks include, but are not limited to:

1. Damage to adjacent structures.
2. Bleeding and/or infection.
3. Adverse effects of anesthesia or analgesics.

I hereby consent to the administration of such anesthetics as may be considered necessary or advisable by physician with the exception of _____

Allergies: _____

I acknowledge that all of my questions concerning this procedure have been answered.

THIS CONSENT IS VALID FOR 1 YEAR AFTER SIGNING.

Date

Signature of Patient

Patient Name - Print

As one of the members of New England Fertility Institute, by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date

Signature of Witness

Witness Name - Print