Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

Cryopreservation of Gonadal Tissue and Cells

Packet Review Consent Form

I have read the provided information on the following treatment(s)/procedure(s):

- ❒ Cryopreservation of Gonadal Tissue and Cells Price List
- ❒ Cryopreservation of Gonadal Tissue (CGT) and Cells Patient Information
- ❒ Cryopreservation of MESA-TESA Sperm SRMS Consent Form
- ❒ Fertility Following Cancer: New Hopes & New Horizons
- ❒ Testing For Sexually Transmitted Diseases
- ❒ ASRM Fact Sheet for Cancer and Fertility Preservation 2003

- ❒ Cryopreservation of Gonadal Tissue Packet Review Consent Form (this form)
- ❒ Billing Information for Transferring Client Depositors From Another Bank
- ❒ XYTEX Semen/Testicular Tissue Services Release to Transfer Form
- ❒ XYTEX Tissue Storage Release to Transfer for Ovarian/Frozen Egg Tissue
- ❒ XYTEX Tissue Storage, INC. Semen/Testicular Tissue Storage Agreement for Client Depositor
- ❒ XYTEX Tissue Storage, INC. Ovarian/Frozen Egg Storage Agreement for Client Depositor

I understand that SRMS is a medical practice pursuant to the rules and regulations of the Florida Board of Medicine. I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have read and understand the above patient information materials, and I have had an opportunity to ask questions regarding the above topics and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medications and/or the performance of particular procedures and wish to proceed with the above treatments and procedures.

_____	___/___/___	_____	___/___/___
Patient Name (print)	Date	Patient Name (signature)	Date
_____	___/___/___	_____	___/___/___
Guardian (if necessary)	Date	Witness	Date
_____	___/___/___		
Practitioner	Date		

Updated: 02/02/2010 K:\docs\forms\Cryopreservation of Gonadal Tissue and Cells Packet Review Consent Form.doc