



**CNY Fertility Center – ART Laboratory**  
**Robert J. Kiltz, MD, Director**  
**195 Intrepid Lane, Syracuse, NY 13205, phone: 315.469.8700**

### **Frozen Embryo Thaw and Transfer Consent**

I/We \_\_\_\_\_ and \_\_\_\_\_ being single/married/unmarried couple, have  
(please circle)  
jointly approved and consented to allow our cryopreserved embryos to be thawed by CNY Fertility, and if viable, transferred into the female partner in an attempt to achieve a pregnancy.

We understand that one, some, or all of our embryos will be thawed according to CNY Fertility protocols and the discretion of the laboratory and or doctor. These embryos will be prepared in the laboratory for a Frozen Embryo Transfer (FET).

We understand that there is no guarantee that the embryos will survive the freezing and thawing process, and that rare equipment failures or laboratory accidents can occur, any of which may cancel the transfer of our embryos. We also understand that there is no guarantee that a pregnancy will occur if or when our embryos are transferred back to the uterus.

If a FET, and a subsequent successful pregnancy occur, we also understand that an ectopic pregnancy, miscarriage, multiple birth, stillbirth and or congenital abnormalities (birth defects) may occur. We understand that the rate of congenital abnormalities (birth defects) in babies conceived naturally is 2-3% and is not known to be different in babies conceived with IVF or FET. We acknowledge that any abnormality of a child conceived through this procedure is not the responsibility of CNY Fertility Center.

We the undersigned have had the opportunity to have all of our questions about the FET process answered to our satisfaction. We also understand the purpose, benefits and risks involved in this procedure.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Partner

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

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