Female Patient Name:_____Social Security #_____

THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY*

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.

Date	**Signature of Patient**	**Patient Name-Print**

As one of the staff members of The Center for Human Reproduction by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date	**Signature of Witness**	**Witness Name-Print**

* Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)