

**CONSENT TO UNDERGO INFERTILITY TREATMENT DURING
THE CORONAVIRUS (COVID-19) PANDEMIC**

COVID-19 is a rapidly evolving pandemic. At the present time, there is limited information about COVID-19, particularly related to its effect on pregnant women or developing fetuses. Furthermore, there are no recommendations specific to pregnant women regarding the evaluation and management of COVID-19.

- There is very little known regarding a pregnant woman's susceptibility to catching COVID-19 or experiencing severe symptoms or dying. The currently available data on COVID-19 does not indicate that pregnant women are at increased risk. However, pregnant women are more susceptible to and at greater risk of mortality and complications from other respiratory infections such as influenza and SARS. Cases of pneumonia in pregnancy may be more severe and require hospitalization and may lead to maternal and fetal compromise.
- There is little known regarding the impact of COVID-19 on pregnancy. High fever from any cause, including COVID-19, in the first trimester of pregnancy, may be associated with an increased risk of birth defects. COVID-19 or seasonal influenza in the third trimester of pregnancy may be more likely to lead to pneumonia. Some infections in later pregnancy may result in stillbirth and preterm birth.
- Adverse infant outcomes, including pre-term birth, have been reported among infants born to mothers positive for COVID-19 during late pregnancy. However, this information is based on limited data and it is not clear whether these outcomes were directly related to maternal infection or not. Currently, it is unclear if COVID-19 can cross the placenta to directly harm the fetus. Although it is unclear what the optimal medical treatments are for this infection, a variety of medications are used to combat the illness. It is possible some of these medications may cause harm to the pregnancy or fetus.

By signing below, I agree to the following statements:

1. At the present time Family Fertility Center does not have access to testing for COVID-19.
2. If I am directly exposed, infected or diagnosed with COVID-19, or have symptoms with any febrile illness, or have flu-like symptoms which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), my/our treatment cycle will be cancelled.
3. My/our treatment cycle may be cancelled if Family Fertility Center is not able to support treatment as a result lack of essential staff or supply shortages.
4. My/our treatment cycle may be cancelled if there is change in regulations at the local, state or federal level such as a government edict, order or directive to stop providing services or procedures, or Family Fertility Center is required to shut down.
5. I may become exposed to COVID-19 while receiving treatment by other patients or a Family Fertility Center staff member or health care provider.
6. The risks of COVID-19 on pregnancy, if any, are unknown but could include, birth defects, miscarriage, stillbirth, preterm birth or other pregnancy complications.

Initials _____/_____

**CONSENT TO UNDERGO INFERTILITY TREATMENT DURING
 THE CORONAVIRUS (COVID-19) PANDEMIC**

7. My treatment cycle may be cancelled if new data arises that mandates cancellation of treatment for my safety or the safety of my future pregnancy or of clinic staff.

8. It has been explained to me that I have the option to postpone treatment in order to minimize the potential risks delineated above.

If the cycle is cancelled for any reason, including, but not limited to, the statements above, this may affect my insurance benefits and/or I may be financially responsible for any services performed, including any medication expenses incurred.

I have discussed the risks and implications of COVID-19 with my physician, and have had an opportunity to ask questions and have them answered to my satisfaction. I understand that information regarding COVID-19 and the medical community's understanding of this disease is rapidly evolving, and that additional risks or considerations may come to light.

By my/our signatures below, I/we confirm that I/we have read the above information on COVID-19, have had an opportunity to discuss this information and our treatment plan with the treating physician, and agree to undergo infertility treatment, including Assisted Reproductive Technology (ART) at this time

Print Name	Signature	Date

Print Name	Signature	Date

The foregoing was read, discussed, and signed in my presence, and in my opinion the person(s) signing did so freely, and with full knowledge and understanding.

Print Name of Witness	Signature	Date

I have explained to the above individual/couple the risks, known and unknown, of undergoing infertility treatment during COVID-19 pandemic as described aforementioned. I have answered all their questions. She/They verbalized understanding of the information conveyed by this document.

H. Christina Lee, M.D., J.D., H.C.L.D.	Date

Initials _____/_____