

**FORM F**  
**CONSENT TO STORAGE OF EMBRYO(S)**  
**OWN  or DONOR**   
**(Clause 18(1) Code of Ethical Clinical Practice)**

I/We .....  
*(print full name of consenting person and consenting partner, if any)*

of .....  
*(print full address)*

**CONFIRM**

- That I/we have received, read and understood the information statement as required by the Code of Ethical Clinical Practice (Reproductive Technology (Clinical Practices) Act 1988).
- That I/we have received information about the procedures relating to the storage and retrieval of embryo(s).

**UNDERSTAND**

- That I/we are entitled to a copy of this completed consent form.
- That I/we have a right to review this consent at intervals of 12 months and that the Licensee\* *in accordance with the Reproductive Technology Act 1988 (consent forms) standard* will, at least 90 days before each anniversary of the date on which we gave the consent, give us written notice of that right.
- That I/we may vary this consent at any time by notice in writing to the Licensee\* *in accordance with the Reproductive Technology Act 1988 (consent forms) standard*.
- That I/we, individually and/or together, may revoke this consent at any time by notice in writing to the Licensee\* *in accordance with the Reproductive Technology Act 1988 (consent forms) standard*.
- That if one or both of us revokes this consent, the Licensee *in accordance with the Reproductive Technology Act 1988 (consent forms) standard* is required to dispose of the embryo(s).
- That unless our consent is given subject to conditions, set out below, specifying how the embryo(s) is/are to be dealt with or disposed of, in the event that I/we die, divorce or legally separate the Licensee *in accordance with the Reproductive Technology Act 1988 (consent forms) standard* is required to dispose of the embryo(s).
- In the event of the breakdown of the relationship it is the responsibility of the male partner to withdraw his consent to the use of any frozen embryo(s) by notice in writing to the Licensee\* *in accordance with the Reproductive Technology Act 1988 (consent forms) standard*. **Failure to do so could result in him being liable for maintenance payments.**
- That in the event that I/we divorce or legally separate the Licensee\* is required to dispose of the embryo(s).
- That pursuant to the Reproductive Technology Act (Clinical Practices) 1988 embryo(s) must not be stored for more than 10 years and must be disposed of at that date. Storage for more than 10 years is prohibited.
- That Repromed has the ability to dispose of embryos if payment is not received.
- That this consent may be given subject to conditions and that provision is made for me/us to specify such conditions below:

.....  
.....  
.....  
.....

\* The Licensee is Adelaide Fertility Centre Pty Ltd trading as Repromed.

**Consent Form F**

Authorised: *[Signature]*

That in the event of my death, disablement or any other inability to state my wishes, I give my partner my full and unconditional consent to have legal possession of all embryos or other genetic material and to use them or dispose of them as seen fit by my partner. To receive treatment in South Australia the remaining partner must meet the normal eligibility criteria of infertility.

**Initial of Consenting Person: ..... Initial of Consenting Partner: ..... Initial of Doctor: .....**

*(Set out in full any conditions, in addition to the conditions stated above, to which the consent is subject. If additional space is required, attach an extra page signed by the consenting person(s) and the medical practitioner.)*

**CONSENT**

**I/We, the abovenamed, having read the contents of this consent form, hereby consent to storage of an embryo(s) on our behalf.**

SIGNED: .....  
 (female partner)  
 .....  
 (print name)

SIGNED: .....  
 (male partner)  
 .....  
 (print name)

DATE: .....

DATE: .....

IN THE PRESENCE OF:.....  
 (Signature of Medical Practitioner)

IN THE PRESENCE OF:.....  
 (Signature of Medical Practitioner)

PRINT FULL NAME OF MEDICAL PRACTITIONER:  
 .....

PRINT FULL NAME OF MEDICAL PRACTITIONER:  
 .....

DATE: .....

DATE: .....

**STATEMENT BY MEDICAL PRACTITIONER**

I ..... (print full name of medical practitioner) confirm that an information statement **Version** \_\_\_\_\_ **20**\_\_\_\_ has been provided to ..... (print full name of consenting person) and to ..... (print full name of consenting partner, if any) in accordance with the Code of Ethical Clinical Practice (Reproductive Technology (Clinical Practices) Act 1988).

**SIGNED BY THE MEDICAL PRACTITIONER :** .....

**DATED THIS** ..... **DAY OF** ..... **20** .....