

## Space for Medical Institution Name and Logo

ט' 2004 / OBGYN/000/IVF/0006 / נובמבר

**טופס הסכמה: מספר העוברים שיוחזר לגוף האישה**

### CONSENT FORM: NUMBER OF EMBRYOS IMPLANTED IN MOTHER

Implantation of fetus/es (fertilized ovum/ova) into the body of the mother (into the uterus or Fallopian tube) is a procedure carried out as part of in vitro fertilization (IVF).

Name of Woman: \_\_\_\_\_  
Last Name First Name Father's Name ID No.

Name of Husband: \_\_\_\_\_  
Last Name First Name Father's Name ID No.

I/we hereby declare and confirm that I/we have received a detailed verbal explanation from:

Dr. \_\_\_\_\_  
Last Name First Name

that as a result of the in vitro fertilization \_\_\_\_\_ \* fetuses have resulted. The number of fetuses that will be implanted will be subject to the directives of the Ministry of Health and in accordance with the recommendations of the Israel Society of Gynecology and Obstetrics.

Having received an explanation concerning the risks and complications to be expected in a pregnancy with multiple fetuses with all its implications, also detailed in paragraph 8 of the consent form for in vitro fertilization (IVF), I/we hereby consent and request to implant \_\_\_\_\_ \* fetuses into the body of the woman (hereafter: the procedure).

I/we know and consent that the procedure will be performed by any designated surgeon, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

\_\_\_\_\_  
Date Time Woman's signature Husband/partner's Signature

I hereby confirm that I provided the woman and the husband /partner \*\* with a detailed verbal explanation of all the abovementioned, as required, and that she/they signed the consent form in my presence after I was convinced that she/they fully understood my explanations.

\_\_\_\_\_  
Physician's name Physician's signature License No.

\*Indicate the number of fetuses clearly and legibly.

\*\* Delete the irrelevant



**Israeli Medical Association**  
Israeli Association of Obstetrics  
and Gynecology



**Ministry of Health**



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**Ministry of Health**



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