ReproMed FERTILITY

CONSENT FOR INITIAL BLOOD SCREENING & ULTRASOUND

Dear Patients,

As part of the overall investigation and treatment of infertility, there are many different tests that need to be completed.

As a policy, we check patients for many different types of infections that can be related to fertility and/or pose a risk to the offspring.

We require your written permission to complete this screening which will include:

Hepatitis A, B, & C	HIVI&II
HTLVI&II	VDRL
CMV	Rubella Immunity
Various Hormones	West Nile Virus
Gonorrhoeae	Chlamydia
CBC	ABO, RhD Antibody Screen

Please Note:
Female patients may also require a transvaginal ultrasound scan as per physician's recommendation. This is an invasive procedure (the probe, covered in a protective shield is inserted into the vagina). This procedure will be performed by an ultrasound technologist/and or physician.

Partners of female patients may require blood tests as well.

*I/We have read the above and hereby give permission for the **BLOOD TESTS** and **ULTRASOUND SCANS** that are required.*

Patient Name: _____ Patient Signature: _____

Date: _____

Partner Name: _____ Partner Signature: _____

Date: _____