**Informed Consent to Storage of Samples and to Results Management
after Preimplantation Genetic Analysis**

*Dear Clients,*

*please read these instructions carefully and sign this informed consent form in witness of your consent to the information stated below.*

1. **Identification data**

|  |  |
| --- | --- |
| **Patient:** |  |
| Name and surname: |  |
| Date of birth/insurance no. (DOB): |  |
| Address: |   |
| **Partner:** |
| Name and surname: |  |
| Date of birth/insurance no. (DOB): |  |
| Address: |  |

1. **Reason for the analysis:**

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| --- |
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|  |

1. **Type of preimplantation analysis**

|  |
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|  |
| * **PGT-M for monogenic disorder + PGT-A of 24 chromosomes**
 | **Karyomapping / OneGenePGT** | [x]  |

**Abbreviations: PGT-A**- ***P****reimplantation* ***G****enetic* ***T****esting of numerical chromosomal changes (****A****neuploidies);* **PGT-M**- ***P****reimplantation* ***G****enetic* ***D****iagnosis/****T****esting for familial* ***M****onogenetic disease –* ***diagnosis can be performed only upon prior performance of SET-UP****.*

1. **Diagnosed material**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞎 | Trophectoderm (blastocyst) – day 5/6 | [ ]  | Other: | ................................................ |

1. **Clients statement**
	1. **Consent to storage of DNA samples used for preimplantation genetic analysis**
	2. We consent to the fact that, if it is possible and/or expedient, the samples are stored for further analysis performed for my benefit or the benefit of biological relatives. Prior to genetic analysis which would be performed for different purposes than those stated above we will be properly instructed and this analysis will not be performed until the new informed consent is signed. The samples will be stored usually for 1 year (however no more than 50 years).
	3. We consent to the use of the stored samples to check the quality of the DNA diagnosis (samples will be used as a control during the analysis of other related persons or when analysing other patients).
	4. We consent to the anonymous use of the analysed samples in medical research (focused particularly on the improvement of the treatment of infertility).

 If you do not consent to any of the above statements, please specify to which one(s):

* 1. **Statement on information about the results of the analysis**
1. We wish to be informed of the results of the laboratory tests, including potential unexpected findings.
2. We wish the following persons to be informed of the results of the laboratory tests and/or unexpected findings:
3. We consent to the use of the results of genetic diagnosis and the relevant information about the health condition for scientific or educational purposes provided that these data are presented and published in full anonymity.

If you do not consent to any of the above statements, please specify to which one(s):

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **We state that we consent to the conditions of the storage above mentioned biological materials and to the management of the results in connection to the performed preimplantation genetic analysis.** |
| We are aware that we can revoke our consent in writing, however only up to the time of the start of preimplantation genetic analysis. |
| In |  | Date |  |
| **Patient’s signature:** |  | **Partner’s signature:** |  |
|  |
|  |
|  |  |  |
| I confirm that I appropriately instructed the applicants about preimplantation genetic analysis and about all the above mentioned facts, and presented them this statement for their signature once they fully understood it. |
| **Clinician’s name and surname:** |  | **Clinician’s signature:** |  |
|  |  |  |  |