Consent Form for Oocyte Cryopreservation
(Social indication)

Fertility Clinic Tokyo
Dr. Kei Odawara

Date of explanation　/　/

Doctor _____

Embryologist _____

cryopreserved oocyte record　frozen day　/　/　(No,　)
frozen day　/　/　(No,　)
frozen day　/　/　(No,　)

Expiration of storage　/　/

I would like to have my oocyte cryopreserved at your clinic because I am concerned about the possibility of a decline in gonadal function due to aging and other factors.

Based on the explanations given by the doctor and the embryologist, as well as the attached document, "Consent Form for Oocyte Cryopreservation (Social indication),"

I fully understand and agree to the terms and conditions regarding the freezing, thawing, and treatment of oocytes.

Please check and fill in the following items

☐ ~~1) Cryopreservation of oocyte.~~

☐ ~~2) The use of medicines to induce follicular growth and ovulation, and the possibility of side effects from egg collection.~~

☐ ~~3) The possibility of not being able to collect the eggs, and the possibility of not being able to freeze them depending on the condition of the eggs.~~

☐ 4) Survival rate of oocyte after freezing and thawing. Depending on the condition of the thawed oocyte, they may not be able to be used for treatment.

☐ 5) The procedure for thawing oocyte.

☐ 6) Procedures for thawing oocyte ICSI and embryo transfer are necessary for treatment with thawed oocytes.

☐ 7) Information on pregnancy rates for treatment using frozen and thawed oocyte.

☐ 8) Cryopreservation period (1 year) and cost of oocyte.

☐ 9) Extension or renewal of the cryopreservation period for oocyte should be limited to a maximum of 50 years of age.

☐ 10) Do you wish to be contacted by e-mail before the expiration date? (Yes ・ No)
The e-mail is an auxiliary means, so please manage the freezing deadlines yourself.
If there is a change in your email address, please change your registration yourself.

☐ 11) I will contact you if there is any change in my address or TEL number.

<Caution>

☐ ~~12) If you do not submit this consent form, you will not be able to cryopreserve your eggs.~~

☐ ~~13) This consent form is only for this cryopreservation of oocyte. If you wish to repeat the freezing process after this freezing, you will be required to submit a consent form for cryopreservation of oocyte each time~~.

☐ 14) In the event of a disaster (natural disaster, fire, etc.), there will be no objection to the damage or loss of oocyte.

☐ ~~15) Even after submitting this consent form, you are free to cancel your consent at any time before freezing.~~

☐ 16) Your personal information will be handled in accordance with the Personal Information Protection Law and the rules of this hospital. Information regarding the course of treatment may be analyzed in a form that does not identify the individual and may be reported to the Japanese Society of Obstetrics and Gynecology.

☐ 17）Medical charges for oocyte freezing are not covered by Public Health Insurance.

Date signed　/　/　　ID No, _____

NAME(**Self written**) _____　TEL _____

Address (〒　-　) _____

Emergency contact：NAME _____ (Relationship) _____

TEL _____　Address(〒　-　) _____