



Consent to Fertility Treatment

- The undersigned hereby request Fertilitetsklinikken Trianglen (CVR 17490141) / Specialists Practice Trianglen (CVR 34205744) to treat our/my infertility by use of assisted reproduction.
- We/I confirm having received adequate information about the treatment, including information about ethical aspects and the undesirable effects and risks, which may be associated with the treatment.
- We/I am aware that adoption may be an alternative to assisted reproduction (*this information is mandatory by law*).

Name of the woman

The woman's CPR-number (social security number) Date (dd/mm/yy) _____
The woman's signature

If you (the woman) do not have a Danish CPR-number, please provide the following:

Date of birth (dd/mm/yy) _____
Passport number _____
Nationality

If the woman is being treated together with a partner, the partner must also give consent to the treatment and accept parenthood.

Please refer to the official Government websites for detailed information about the legislation.

- I undersigned (partner) hereby accept that my wife/partner is treated by assisted reproduction techniques by or under the supervision of a medical doctor. I also declare that I will be the legal and social father or co-mother of the child/children that may result from the treatment.

Name of the partner (if partner)

The partner's CPR-number (social security number) Date (dd/mm/yy) _____
The partner's signature

If you (the partner) do not have a Danish CPR-number, please provide the following:

Date of birth (dd/mm/yy) _____
Passport number _____
Nationality

Please also see and sign page 2.....

Privacy policy and General Data Protection Regulation (GDPR)

- I accept that personal information about me is registered and stored in connection with the treatment. Information is handled according to the GDPR.
- I accept that information registered and stored in connection with the treatment can be exchanged between Fertilitetsklinikken Trianglen and Specialist Practice Trianglen to the extent necessary for any current or future fertility treatment.

See details in our Privacy Policy and at trianglen.com.

Date (dd/mm/yy)

The woman's signature

The partner's signature
(if partner)

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Payment

For patients **with a Danish social security number** (CPR-number) the following is covered by the Danish National Health Insurance ('Regionen'):

- For couples or single women:
AI diagnostic work-up, ultrasound scans, insemination etc. if both partners have a referral from their doctor.

The National Health Insurance ('Regionen') does *not* cover

- Treatment with/use of *donor*-sperm
- Treatment with IVF, ICSI, TESA, frozen embryo replacement etc.

These treatments are performed by Fertilitetsklinikken Trianglen Aps and must be paid according to the current price list.

Medicine must be paid by the couple/woman. Medicine is not included in the price for treatment.

We/I accept the above regarding payment

Date (dd/mm/yy)

The woman's signature

The partner's signature
(if partner)

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Information from other clinics or laboratories

In connection with the fertility treatment it may be of importance for us to obtain information about previous blood tests, other tests and previous treatments.

We/I accept that Trianglen can request relevant information from other clinics, hospitals, laboratories etc.

Date (dd/mm/yy)

The woman's signature

The partner's signature
(if partner)

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The referring doctor/general practitioner is normally informed about the treatment and the outcome of it. If you cannot accept this, you must specifically tell us so, so we can abstain from passing this information.