Consent to Fertility Treatment

This consent is valid for 2 (two) years unless withdrawn before in writing.

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

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 *Date (dd/mm/yy)* *The partner's signature*
(social security number)

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.
- I accept that if Trianglen ceases operation or is merged with another approved clinic / tissue center, then my personal information can be passed on to the clinic that takes over Trianglen's information and obligations.

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.