

מס' זהות:	שם פרטי:
שם משפחה:	תאריך לידה:
שם האב:	
כתובת:	
טלפון:	

מדבקת פרטי מטופל

טופס הסכמה: הזרעה מלאכותית עם זרע של תורם לאישה
CONSENT FORM: ARTIFICIAL INSEMINATION
DONOR – SINGLE WOMAN

The insemination is conducted using a frozen sperm suspension only, taken from a well-known sperm bank, licensed by the Ministry of Health.

The sperm suspension is injected into the womb using a sterile catheter, through an intra-vaginal, intra-cervical or intra-uterine approach. The known chances of treatment success depend on the causes of infertility, and are approximately 15% per one treatment course.

Name of Woman: _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____

Last Name First Name
regarding the donor insemination, the tests and treatments involved, the method of performance and chances of success (henceforth: "the treatment").

I have been given an explanation concerning the possible side effects including: mild abdominal pain and mild hemorrhage, which subside gradually within a few hours of the insemination.

In addition, I have been given an explanation concerning the possible complication of infection of the internal genitalia, which may be accompanied by pain and/or high fever and will require hospitalization, and in rare cases, cause obstruction of the fallopian tubes.

I have been told that the use of frozen sperm, despite all the tests performed on it, is not completely devoid of the possibility of disease transmission.

I have been told that there is no guarantee that I will conceive as a result of the insemination, or that I will give birth as a result of the insemination.

In addition, there is a possibility of complications during the pregnancy and delivery, and the possibility that the child(ren) born may be physically or mentally abnormal, or suffer from defects, or abnormalities, as well as genetic predispositions or any other anomaly, just as in natural pregnancies.

I agree that the donor or donors of the sperm used to inseminate me, or the sperm itself, will be selected by the physician, exclusively at his/her discretion and that I will not be entitled to know the identity of the man whose sperm was used to inseminate me, nor his characteristics, or any other details related to him or his family.

I hereby give my consent to perform the treatment.

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I know and agree that the treatment will be performed by any designated person, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

I hereby waive, on behalf of myself, on behalf of my heirs, estate and legal representatives and on behalf of any person acting in my name, any claim or demand of any kind with regards to, or derived from the tests and treatments performed for the artificial insemination, from the insemination itself, from the selection of the sperm and donor or his personal, genetic, spiritual and physical characteristics, his country of origin or ethnicity, and concerning the child(ren) born, if born, his/her/their sex, external appearance, nature, characteristics or health condition.

I agree and declare that the child(ren) born of the insemination will carry my name and be considered my son(s)/daughter(s) for all purposes, including alimony and inheritance.

_____ Date _____ Woman's Signature

I hereby confirm that I have given the woman a detailed oral explanation of all the above-mentioned facts and considerations as required and that she has signed the consent form in my presence after I was convinced that she fully understood my explanations.

_____ Name of Physician _____ Physician Signature _____ License No.