Centre for Reproductive Medicine





Egg disposal tick list

	Patient Name:		
	Address:		
	Date of Birth: Hosp No (if known):		
All sections below MUST be completed Please be aware that if you have previously consented to training, this may be included as part of the disposal process			
	ate your wish for your stored frozen eggs: e option only		
Allowed to perish			
Donate to research Now complete the 'Indicators of oocyte and embryo development' consent form			
Please s	ate which egg cycles this applies to - Tick one op	tion only	
All eggs, fr	om all cycles		
Only certain eggs (see below)			
If only certa	ain eggs, please specify:		
	ATION: You MUST include a copy of photo identification		
I have enclosed proof of identification e.g. passport or driving license (please tick)			
DECLARA	TION - Please SIGN below		
Patient sig	nature	Date	

Author: J Rai Note: This document is not controlled if printed.

Document Location: QM computer, I drive (emb consent forms)
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