

**INFERTILITY & IVF MEDICAL ASSOCIATES OF WESTERN NEW YORK**

**CRYOPRESERVATION OF SEMEN**

**BUFFALOIVF.COM**

*When you have scheduled your appointment with Dr Crickard or Dr Sullivan to sign the consent, please bring this packet...*

**INFERTILITY & IVF MEDICAL ASSOCIATES OF WNY**

**Hemlata S. Bhakoo, Ph.D.**  
**Director, IVF Andrology Laboratory**  
**4510 Main Street**  
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**Tel: 716/839-5198**  
**FAX: (716) 839-1477**

Dear Sir:

In response to your request for cryopreservation of Semen/Sperm, please find enclosed information which we hope will answer many of your questions or concerns regarding cryopreservation of semen. Please note the requirements listed.

If you have questions or require further information, please call the IVF Andrology Laboratory at 839-5198.

Kent Crickard, M.D.  
Director, IVF Program  
Michael W. Sullivan, M.D.  
Co-Director, IVF Program

## **Patient Information for Semen/Sperm Banking**

### ***Why is sperm banking performed?***

In cases where the male partner is unavailable at the time artificial insemination or In Vitro Fertilization will be performed, it is necessary to cryopreserve sperm for future use.

Additionally, patients requiring surgery and/or chemotherapy for various types of cancer are advised to cryopreserve sperm for future use. In most cases, sperm are severely compromised after chemotherapy/radiation treatment and it is recommended that sperm is cryopreserved *before* any chemotherapy/radiation treatment is started.

### ***How is cryopreserved sperm used?***

Depending on the quality and volume, one semen sample usually yields enough sperm for one attempt (possibly two attempts) at artificial insemination. Artificial insemination requires a large volume of sperm injected into the female.

If there is low volume or poor quality of sperm, it may be necessary to have In Vitro Fertilization (IVF) as IVF only requires one or two sperm. This should be discussed with one of our physicians.

### ***How long can sperm be cryopreserved?***

After the sperm are frozen, a small portion is removed 48 hours later to test the freezing post-thaw survival and motility. This will give an indication of the effects of freezing on the sperm and the usefulness of frozen storage.

There is no guarantee that the sperm will survive long-term storage. Although there has been successful storage of semen with subsequent pregnancy after 12 years of storage, there is some evidence that there may be degradation in some samples. This may compromise the ability of the sperm to fertilize an egg.

## Requirements for Semen/Sperm Banking

### **BEFORE SEMEN FREEZING:**

1. Make Appointments:

**1<sup>st</sup> Appointment:** You and your wife or partner must schedule an appointment with Drs. Kent Crickard or Michael Sullivan to review and sign the consent form for cryopreserving your semen specimen. **Call the office for an appointment at 839-3057.** This office visit will be billed to your insurance as an infertility visit and you must provide your insurance information and obtain an insurance referral if required.

**2<sup>nd</sup> Appointment:** After you have met with the doctor, call the IVF/Andrology Laboratory at 839-5198 to schedule the cryopreservation.

**Note: If there are time constraints, the appointment with the physician and obtaining the first specimen can be scheduled on the same day...**

2. Review Consent Form - Please review the attached consent form but **do not sign** until your appointment with Drs. Crickard or Sullivan. If you have any questions, they will be discussed at your visit.

3. Laboratory Testing – All patients having cryopreservation of semen must complete the tests listed below. This testing will be done at your office visit to sign consent. These tests are usually covered by insurance, however, if your insurance requires laboratory testing with your primary physician, ask your primary physician to order these tests. **Testing must be performed within one month of your sperm banking and the results sent to this facility prior to freezing.**

HIV-1 and HIV-2 RPR	Hepatitis B surface antigen Hepatitis B core antibody	Hepatitis C CMV (IgG and IgM)
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**Please Note:** Infertility & IVF Medical Associates of WNY is not equipped to store biohazardous specimens. If testing for HIV 1 and/or HIV 2 are positive, the specimens cannot be stored here and must be shipped to another facility or destroyed upon your final authorization. Furthermore, this testing will give reasonable assurance that the specimens can be safely used in the future for insemination or In Vitro Fertilization. For complete assurance, you can be tested for HIV six months after your last specimen is stored.

3. Storage Fee – The fee for processing and cryopreservation is listed below. Please note this fee must be paid before freezing.

\$400.00	-	(2 samples) analyses, processing, cryo and storage for the first year
\$150.00	-	3 <sup>rd</sup> specimen (fee for additional specimens – determined by the physician)
\$200.00	-	storage per year after the first year

### **DAY OF SEMEN FREEZE:**

See "Instructions for Obtaining Semen for Freezing" attached...

**INFERTILITY & IVF MEDICAL ASSOCIATES OF WNY****Consent Form  
Cryopreservation of Semen/Sperm**

I, \_\_\_\_\_ wish to preserve my sperm by  
*patient*

cryopreservation (freezing) in the IVF Andrology Laboratory at Infertility & IVF Medical Associates of Western New York. I understand that the semen sample(s) will be frozen according to laboratory procedure and a small portion removed 48 hours later to test the freezing post-thaw motility and survival. This will give an indication of the effects of freezing on the sperm sample and the usefulness of frozen storage.

I further understand that:

1. The Infertility & IVF Associates of WNY will make all reasonable efforts to keep the frozen sperm safe. The facility is always locked with a security system and no unauthorized persons are allowed in the IVF Andrology Laboratory. There is no guarantee that the sperm will survive long-term storage. Although there has been successful storage of sperm with subsequent pregnancy after 12 years of storage, there is some evidence that there may be degradation in some samples after a few years or sooner. Furthermore, the possibility does exist that under unusual circumstances or situations beyond the Laboratory's control (such as, but not limited to, power failure, breakage of the tanks, loss of liquid nitrogen), specimens may thaw and no longer be viable. I have been informed of these possibilities and accept these risks upon entering into the cryopreservation program and signing this Agreement, I realize that the Laboratory staff checks the cryotanks on a daily basis, including holidays and will take suitable precautions so that the specimens are safe and do not thaw.
2. I understand that physicians and staff at Infertility & IVF Medical Associates of WNY are not obligated to proceed with any procedure to implant my sperm for the purpose of insemination. The IVF Andrology Laboratory staff also retains the right to terminate its participation in sperm bank procedures for any reasons that it may determine to be appropriate. In any circumstance, when such procedures are terminated and cryopreserved sperm remain in storage, the laboratory will arrange for the transfer/disposal of such sperm in accordance with my desires and at my expense in accordance with this Agreement.
3. Although there are no guarantees, current available evidence suggests that there is no increased risk of genetic defects attributable to the freezing and thawing of sperm specimens.

4. I agree to have the required laboratory tests listed below with results sent to Infertility & IVF Medical Associates of WNY prior to cryopreservation. The IVF Andrology Laboratory does not have the capacity to store biohazardous specimens, therefore, I must be tested for sexually transmitted disease. The IVF Andrology Laboratory at Infertility & IVF Medical Associates of WNY will not store sperm specimens unless the tests are negative. I also hereby release from any liability the IVF Andrology Laboratory at Infertility & IVF Medical Associates of WNY in the event that sexually transmitted disease transmission occurs from a future insemination of my wife or intimate partner with my stored sperm.

Required Tests:	HIV-1 & HIV-2	Hepatitis B surface antigen
	RPR	Hepatitis B core antibody
	CMV (IgG and IgM)	Hepatitis C

5. I hereby agree and acknowledge that any sperm which Dr. Kent Crickard or Dr. Michael W. Sullivan at Infertility & IVF Medical Associates of WNY determine in the exercise of reasonable medical judgment are non-viable or otherwise not medically suitable for continued use, may be disposed of in accordance with IVF Andrology Laboratory policies.
6. In the event that I should die or become incompetent, that my marriage is dissolved because of dissolution proceedings or death, or if my wife or intimate partner experiences a hysterectomy, or is determined to be incapable of achieving a pregnancy, I agree that the sperm held by the IVF Andrology Laboratory at Infertility & IVF Medical Associates of WNY in accordance with this Agreement and/or in accordance with applicable laws shall and be owned and controlled in accordance with laboratory policies and applicable legal and ethical principles. My stored sperm will never be used for insemination of a woman (or women) unknown to me. Only I can authorize the use of the sperm for insemination of my wife or intimate partner.
7. The stored sperm shall be destroyed upon the IVF Andrology Laboratory's receipt of a copy of a death certificate in the event of my death, or upon the Laboratory's receipt of a Consent to Destroy Semen Specimen requesting that the sperm be destroyed; this Consent must have my notarized signature. Upon receipt of the Consent to Destroy Semen Specimen, the sperm will be held for a maximum of one month and will then be destroyed.
8. I agree to pay a fee (which I hereby acknowledge has already been discussed with me and provided in writing) for any initial work-up, processing and yearly storage of the sperm. If I do not pay these fees and I have been contacted by the Laboratory by telephone and in writing and I fail to respond within 30 days, I am aware that the IVF Andrology Laboratory is authorized by New York State regulations, to destroy the stored sperm after such 30 day period of non-payment and non-response on my part.
9. Multiple sperm samples may be needed to establish adequate amounts of sperm specimens to be used to achieve a pregnancy in a reasonable period of time. This has or will be discussed upon my request.

**Note:** Typically, one specimen is sufficient for **one** IUI or IVF Procedure.

- 10. I have scheduled a consultation with Dr. Kent Crickard or Dr. Michael Sullivan (839-3057) to discuss all aspects of the sperm banking and to ask any and all questions relative to this procedure. If I choose not to have this consultation, I hereby agree to release from any liability the IVF Andrology Laboratory at Infertility & IVF Medical Associates of WNY because I did not have appropriate information.
- 11. I will notify Infertility & IVF Medical Associates of WNY of any address or status change as soon as possible.

**SPERM DISPOSITION:**

In the event of my death, the following options are given as to the disposition of my stored sperm:

- A. \_\_\_\_\_ thaw and no further action taken
- B. \_\_\_\_\_ donated for research purpose
- D. \_\_\_\_\_ other (*explain*) \_\_\_\_\_  
\_\_\_\_\_

**SEMEN CRYOPRESERVATION FEES: *Signed Consents and processing fees are required before freezing...***

- \$400.00 - (2 samples) analyses, processing, cryo and storage for the first year
- \$150.00 - 3<sup>rd</sup> specimen (fee for additional specimens – determined by the physician)
- \$200.00 - storage per year after the first year

\_\_\_\_\_  
patient signature

\_\_\_\_\_  
date

\_\_\_\_\_  
physician/witness signature

\_\_\_\_\_  
date

## INFERTILITY & IVF MEDICAL ASSOCIATES OF WNY

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**Director, IVF Andrology Laboratory**  
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### INSTRUCTIONS FOR OBTAINING SEMEN FOR FREEZING

1. Appointments:
  - Schedule appointment with Drs. Kent Crickard or Michael Sullivan to discuss the Cryopreservation process and sign consent form.
  - **Call the IVF Andrology Laboratory (839-5198) to schedule an appointment for semen freezing.**
  
2. Collecting the specimen:
  - No sexual activity (including masturbation) for at least 2 days but not more than 4 days before collecting the specimen.
  - You may collect the specimen either at home (provided the sample can be at the office within 1 hour) **OR** in the privacy of a room in the office.
  - Collect the specimen using the sterile container provided by our office or you may purchase a “sterile container” at any pharmacy.
  - The method of choice for collection of a semen specimen is masturbation. If you must obtain the specimen through intercourse, you **must** use a non-toxic sterile condom purchased from this office – *do not use a regular condom...*
  - Be sure to note the method of collection on the attached form.
  
3. After specimen collection:
  - Mark the specimen container with your name, date of birth, wife’s name, the date and time of specimen (make sure the lid is securely in place).
  - For transport of specimen to the office:  
 Winter months – keep specimen warm in a coat pocket  
 Summer months – protect specimen from direct sunlight
  - Complete the attached form and bring it to the office with your specimen.
  
4. Payment: **Payment is due at the time of service.**
  - \$400.00 - (2 samples) analyses, processing, cryo and storage for the first year
  - \$150.00 - 3<sup>rd</sup> specimen (fee for additional specimens – determined by physician)
  - \$200.00 - storage per year after the first year

**Note:** Typically, one specimen is sufficient for **one** IUI or IVF Procedure.
  
5. Semen analysis results:
  - After one week, call the office (839-3057) for your results.

## IVF Andrology Laboratory

### Semen Collection Information Sheet– 1<sup>st</sup> Semen Freeze

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Telephone: \_\_\_\_\_

Wife/Partner: \_\_\_\_\_ Wife's Doctor: Drs. Crickard / Sperrazza / Sullivan  
*circle one*

**OR**

If you are not a patient here, list your Referring Doctor: \_\_\_\_\_

1. Semen sample collected by: \_\_\_\_\_  
*address*

\_\_\_\_\_ Masturbation

\_\_\_\_\_ Sterile condom with intercourse

\_\_\_\_\_ Other: \_\_\_\_\_

*please specify*

2. Date and time of semen sample collection: \_\_\_\_\_

3. Was any of the sample lost during collection: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, did the loss result from any of the following:

\_\_\_\_\_ missed container - which portion of the ejaculate was lost? first / middle / last  
*circle*

\_\_\_\_\_ Spillage

4. Semen sample was collected at:

\_\_\_\_\_ at home/other location

If yes, approximately how far was the sample transported? \_\_\_\_\_

5. Was any of the sample spilled while bringing it to the office? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much of the sample was lost? 25% / 50% / 75% / 100%

*circle one*

6. Number of days since your last ejaculate: \_\_\_\_\_

7. Average number of times you ejaculate per week: \_\_\_\_\_

8. List your current medications: \_\_\_\_\_

#### ***To be completed by laboratory personnel***

Date & Time of arrival: \_\_\_\_\_ Initials: \_\_\_\_\_

Any apparent loss of sample? Yes \_\_\_\_\_ No \_\_\_\_\_

**IVF Andrology Laboratory**

**Semen Collection Information Sheet – 2<sup>nd</sup> Semen Freeze**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Telephone: \_\_\_\_\_

Wife/Partner: \_\_\_\_\_ Wife's Doctor: Drs. Crickard / Sperrazza / Sullivan  
*circle one*

**OR**

If you are not a patient here, list your Referring Doctor: \_\_\_\_\_

2. Semen sample collected by: \_\_\_\_\_  
*address*

\_\_\_\_\_ Masturbation

\_\_\_\_\_ Sterile condom with intercourse

\_\_\_\_\_ Other: \_\_\_\_\_  
*please specify*

2. Date and time of semen sample collection: \_\_\_\_\_

3. Was any of the sample lost during collection: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, did the loss result from any of the following:

\_\_\_\_\_ missed container - which portion of the ejaculate was lost? first / middle / last  
*circle*

\_\_\_\_\_ Spillage

5. Semen sample was collected at:

\_\_\_\_\_ at home/other location

If yes, approximately how far was the sample transported? \_\_\_\_\_

5. Was any of the sample spilled while bringing it to the office? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much of the sample was lost? 25% / 50% / 75% / 100%  
*circle one*

9. Number of days since your last ejaculate: \_\_\_\_\_

10. Average number of times you ejaculate per week: \_\_\_\_\_

11. List your current medications: \_\_\_\_\_

***To be completed by laboratory personnel***

Date & Time of arrival: \_\_\_\_\_ Initials: \_\_\_\_\_

Any apparent loss of sample? Yes \_\_\_\_\_ No \_\_\_\_\_

