

**Delaware Valley Institute of Fertility & Genetics
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**PERIPHERAL BLOOD COLLECTION
INFORMED CONSENT**

1. I agree to the insertion of a peripheral blood collection device by a trained professional.
2. The insertion procedure and complications have been explained to me and I understand them.
3. I realize that this is an invasive procedure and has certain risks such as infection, bruising, vein inflammation, and nerve damage.
4. I understand that a needle no longer than 1-__ inches will be placed in my arm.
5. I have the right to voice any questions I may have about this procedure and I expect knowledgeable answers. I also understand that there are specific policies relating to the care which will be given to me and include provisions for termination of services at my request, the request of physician, and/or at the decision of the agency. I agree to abide by the terms of these policies in all respects.

Patient Signature

Date

Witness

Date