IVF PROGRAM

VERMONT CENTER FOR REPRODUCTIVE MEDICINE

A WORKBOOK TO GUIDE YOU THROUGH YOUR CYCLE

Updated February 2009
THE IVF TEAM

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ABOUT OUR PROGRAM...

Reproductive Endocrinology and Infertility is a division of the Department of Obstetrics and Gynecology (Women’s Health Care Service) at Fletcher Allen Health Care. Our IVF program is comprised of highly skilled physicians, nurses, embryologists, and other health care professionals dedicated to providing you with advanced infertility care and treatment. It is our experience that this is best accomplished by a team approach, working in collaboration with you and your partner to develop an individualized treatment plan. We encourage you to participate in this ongoing process.

WHO IS “THE TEAM”

As you progress through your cycle you will see some or all of the various team members. Be assured that each member is aware of your current status. The IVF coordinator is your contact person, and if necessary can put you in touch with other team members. You are an important team member as well, and good communication between you and the rest of the team is vital! Many couples/individuals find this infertility treatment (IVF) to be unusually stressful, often leading to feelings of frustration and disappointment. Our experience has shown that open communication between you and the rest of the team is imperative, and we encourage you to discuss any problems with us.

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IVF FEES AND INSURANCE COVERAGE

After you have decided that you would like to proceed with IVF, you will want to research your insurance benefits to determine if they cover the cost of the IVF procedure and the medications that are involved in the process. If you do not have insurance coverage for IVF, then we require payment in full prior to the start of the IVF cycle. This payment is referred to as the global fee. Fletcher Allen Health Care has developed the global fee structure based on the services you will receive during an IVF cycle particular to your situation.

There are two main types of global fee. One global fee type is intended to cover only the fees associated with the actual IVF retrieval and embryo transfer. In this case, your cycle monitoring ultrasounds and associated estrogen blood tests will be charged to your insurance. You will be responsible for the resulting balance if not covered by insurance. The other global fee charge encompasses both cycle monitoring ultrasounds, estrogen blood tests, and the retrieval and embryo transfer. In addition, to the global fee charge, you will be billed separately for the medication charges. If you elect to cryopreserve remaining embryos for future use, the embryo cryopreservation and embryo storage charges will also be billed separately. If you require services from an urologist, their fees will be billed separately from their office.

Katie Callan, our Precertification Associate, is available to assist you in determining your insurance coverage for IVF. She will obtain information from your insurance company about your benefits and will document this information in your chart. Please contact Katie Callan at 802-847-9470 prior to starting the work-up process.

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**IVF Work-up**

After your initial consultation with the IVF physician and Fellow, your doctor will determine what work-up will be required of you and/or your partner. It is required that your work-up be completed before you begin your IVF cycle. Each work-up plan may be different from patient to patient based on your individual infertility history. Listed below are the typical tests and visits that may be required by your doctor.

**__IVF TALK WITH PHYSICIAN__**

You must have an appointment with your IVF physician and/or the REI third year Fellow within 6 months of beginning your IVF cycle.

**__CALL KATIE CALLAN FOR PRECERTIFICATION__**

Call Katie Callan at (802) 847-9470 and she will contact your insurance company to find out what your benefits include, prior to proceeding with the work-up for IVF.

**__TALK WITH COORDINATOR__**

You and your partner must attend a talk with the IVF Coordinator. This talk lasts about an hour. The content of this talk includes a detailed overview of the IVF process as well as specific information concerning cost, medication use, patient responsibilities, review of consent forms, and the decision-making processes involved in a cycle.

**__SEmen ANALYSIS__**

A semen analysis must be performed within 2 years of your cycle. The semen analysis is a detailed evaluation of the sperm’s ability to undergo the process used during an IVF cycle. Semen morphology (an evaluation of the ratio between abnormal and normal sperm forms) will be included in the analysis.

**__HYSTEROSALPINGOGRAM (HSG)/SONOHYSTOGRAM__**

An HSG is an x-ray dye study to evaluate the uterine cavity and tubal patency. This test is done in the Radiology Dept. at MCHV. A sonohystogram is done at our office. Saline is injected into the uterus and the cavity is assessed using transvaginal ultrasound. Your physician will decide which of the tests is appropriate for you. This test must be done within 6 months of your cycle.

**__PAP SMEAR__** to be done within 1 year of the cycle.

**__SCREENING BLOODWORK__**

Bloodwork needs to be performed for both partners within one year of the cycle. This includes screening for HIV, Hepatitis B and C, Syphilis, and Rubella.

**__CYCLE DAY 3 FSH__** within six months of the start of cycle.

**__CERVICAL CULTURES FOR GONORRHEA AND CHLAMYDIA__** within one year of cycle.

**__Talk with Psychologist---Optional__**

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COORDINATION AND SCHEDULING OF YOUR IVF CYCLE

Once you have completed the work up for your IVF cycle you will need to call the IVF coordinator at (802) 847-0986. Your chart will be brought to the next meeting of the IVF team and will be presented for review. At this weekly meeting we will determine what your treatment plan will be. The type and dose of Gonadotropin medication will be determined. After we establish your treatment plan, we will schedule a “Coordinator Talk” for both you and your partner to attend.

Talk with IVF Nurse Coordinator

You and your partner will be required to attend a Coordinator Talk before you are able to proceed with your IVF cycle. (At this point you should be on the birth control pill. Please inform the IVF nurses if you are not yet on the pill.) At the coordinator talk you will:

1. Discuss your treatment plan and review the schedule of your cycle.
2. Learn how to properly administer the injectable medications and review the side effects of these medications.
3. Sign consent forms for the procedure.
4. Receive all medications for your cycle.

*** We recommend that both you and your partner read through your IVF binder before attending your Coordinator talk so that you will be familiar with the information that is reviewed and will be prepared to ask any questions that you may have regarding your cycle. In particular, it is important to have read the consent forms so that your questions can be answered before signing the consents at this visit.

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Baseline Visit

Your baseline appointment is the first ultrasound you will have before you begin your Gonadotropin medications. You should have all of your medications and supplies by this visit and if your medication plan includes Lupron, you will have been on Lupron at least 10 days at this point. You should weigh yourself on this day and record your weight in your binder. This appointment will be scheduled in the morning and will be approximately 1 hour in duration. You will need to come to this appointment with a semi-full bladder. This visit will include:

1. A blood draw to determine your estrogen level.
2. A vaginal ultrasound to determine if your ovaries are “clear” (without follicular activity).
3. A trial pass of the embryo catheter by ultrasound guidance to determine the depth of the uterus for proper placement of embryos and also to determine a pathway for the catheter for an easy pass at the actual embryo transfer.
5. A brief history and physical with the Physician.

You will be notified by one of the IVF nurses the afternoon of the day of your baseline appointment whether or not you can begin your Gonadotropin medications. It is very important that we are able to reach you that afternoon before our office closes. Please do not start any medications until you are given the “OK” by one of the IVF nurses.
First Follow-up Ultrasound Visit

Your first follow-up visit occurs after you have been on Gonadotropins for 3-5 days depending on your individual treatment plan. At your first follow up visit you can expect to:

1. Have blood drawn to measure your Estrogen level.
2. Have a transvaginal ultrasound.

One of the IVF nurses will call you the afternoon of your appointment to notify you of any changes that are needed in the dosage of your medications. From this point on it is more difficult to predict when you will need to be seen for a follow-up visit. Most women will require additional stimulation, however some women may stimulate quickly and be ready for HCG by their first or second follow-up visit. Information from your ultrasound, as well as your estrogen level will help the team decide when to see you again. Your “plan” will be explained to you by one of the IVF nurses over the telephone on the afternoon of your follow-up visit. Additional follow-up visits will be scheduled at that time as needed.

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Retrieval Instructions

When you have an adequate number of mature follicles, one of the IVF nurses will call you to schedule you egg retrieval. The retrieval will take place 35 hours after you take the HCG injection. The nurses will give you a specific time that you will need to administer your HCG injection. **Adherence to this schedule is essential because of the timing of the retrieval.**

Below is a list of instructions that the nurse will give both you and your partner when the IVF egg retrieval is scheduled.

**For the female:**

1. Do not eat or drink anything after midnight on the evening before your egg retrieval.

2. The procedure will take place in the specialized IVF procedure and recovery area at the Gynecology Outpatient Clinic, 4th floor, in the main pavilion of the Ambulatory Care Center. Check in at the main patient registration desk on the third floor of the Ambulatory Care Center prior to arriving at our clinic.

3. You will remain in the recovery room 1-2 hours after the egg retrieval. Someone may stay with you during this time. Please make arrangements for someone to drive you home since you will be unable to drive yourself.

4. Start the Progesterone vaginal suppositories in the afternoon of the retrieval. On the retrieval day you will take one suppository that afternoon and one that evening. The day after the retrieval you will insert one suppository three times a day.

**For the male:**

1. There will usually be one semen collection on the day of the egg retrieval. The best fresh specimen is with 2-5 days of abstinence. Therefore, plan an ejaculation on the day your wife will do her HCG injection. Do not have intercourse or an ejaculation from that time (the day of HCG) until the specimen is collected the day of the retrieval.

2. You will be instructed to collect your specimen while your wife is in the retrieval and will be notified if more than one sample is required. **Do not leave until you have been informed the sample is adequate.** There will be a form to fill out and the staff will verify your name and date of birth.

3. Collect the entire ejaculation in the special sterile container provided. To avoid contamination, do not use lubricants.

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4. After collection, your sample will be given directly to an IVF staff member, who will once again verify your information. If the sample is collected off site, keep it at body temperature and deliver it to the designated area within one hour of ejaculation.
Embryo Transfer Instructions

On the day before the embryo transfer one of the nurses will call you to give you the time of your transfer. Below is a list of instructions that the IVF nurse will give you the day before your transfer.

1. Check in to the patient registration desk on the third floor of the Ambulatory Care Center at the designated time and then arrive at the Gynecology Outpatient Clinic for your procedure.

2. Arrive with a SEMI-FULL bladder.

3. The embryo transfer will be performed while you are on your back. Once the embryos have been transferred to the uterus you will remain on your back for one hour. The physician will empty your bladder with a catheter after your transfer is completed.

4. It is not known if activity after the transfer has any effect on the outcome of an IVF cycle. We recommend that you remain quiet for 24 hours after the Embryo Transfer and do no strenuous activity until the results of your pregnancy test are known. You should abstain from sexual intercourse/orgasm, tampon use and douching until the results of your pregnancy test are known.

5. Continue your Progesterone Vaginal Suppositories three times a day until the results of your pregnancy test are known. If your pregnancy test results are NEGATIVE- you will then be told to discontinue your progesterone and estrogen, if you are using estrogen,and your menses should begin within a few days. If the result of your pregnancy test is POSITIVE- you will remain on progesterone and estrogen until you are ten weeks pregnant. The IVF team will give you the date that you can stop your suppositories.

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Post IVF Instructions

After your embryo transfer, please be sure to contact one of the IVF nurses to schedule your pregnancy test. The first pregnancy test is done 9-14 days after the embryos are transferred to your uterus. You will need to have your blood drawn either at Fletcher Allen or at a hospital that is nearest to you. The nurses will help you arrange your testing. **IT IS IMPORTANT FOR YOU TO REMEMBER THAT EVEN IF YOU ARE HAVING VAGINAL BLEEDING AT THE TIME OF YOUR FIRST PREGNANCY TEST WE WILL STILL REQUIRE A BLOOD TEST TO CONFIRM YOUR RESULT.** We will not know the results of the pregnancy test until the afternoon the day the test is drawn. If your test is positive, we will repeat your blood test in 48 hours. If your test is negative, we ask that you make every effort possible to schedule a post-IVF visit. This is an important time for us to review your cycle. If you have frozen embryos, we can discuss the possibility of proceeding with a frozen embryo transfer at this visit.

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**LUPRON**

Lupron is given subcutaneously (SC) starting one week before an expected menstrual period or after taking oral contraceptives for at least fifteen days. A full dose is taken daily until Gonadotropins are initiated, then $\frac{1}{2}$ dose is taken daily and CONTINUED UNTIL hCG IS GIVEN. Your physician will determine what dosage of Lupron you will start with as the dosage can vary from patient to patient. Take this medication about the same time each day. You may take it either in the AM or PM, but once decided, you must keep to the same schedule. Keep each unopened vial refrigerated until ready to use. Remember, an opened Lupron vial is good for 60 days if stored in the refrigerator, and 30 days if not.

**INJECTION TECHNIQUE FOR LUPRON**

1. Pull air into the syringe equal to the amount of medication that you will be injecting.
2. Inject air into the Lupron bottle.
3. Turn bottle upside down with the needle still in the rubber dome.
4. Pull back the plunger hard and quick to the specified dosage of Lupron that you have been prescribed. (You may overfill and then push back medication back into the vial to get out air bubbles.)
5. Turn bottle right side up and withdraw needle.
6. Flick to remove any air bubbles.
7. Prepare area along either thigh or in abdomen. (You should rotate the site with each injection of medication.) Pinch skin, cleanse with alcohol and allow area to dry.
8. Hold syringe perpendicular to skin and insert entire needle quickly into site.
9. Inject medication, withdraw needle and hold pressure with cotton.
10. Area may bleed—hold pressure. Clear fluid may leak from site—it is ok. Hold pressure. Area may bruise—don’t give another injection in that site.

**SIDE EFFECTS:**

Lupron is the medication which shuts down production of some of your female hormones, and, in effect, puts you into a menopausal-like state. The annoying side effects you MAY experience include: hot flashes, frontal headache, and/or mood swings.

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INJECTION TECHNIQUE FOR GANERELIX (ANTAGON)

The doctor will determine when you should start using Ganerelix. This is based on follicular size and estrogen level.

The Ganerelix is packaged in a prefilled syringe. You will not need to perform and mixing or change needles before using your Ganerelix.

Prepare area along either thigh or in abdomen. (You should rotate the site with each injection of medication.) Pinch skin, cleanse with alcohol and allow area to dry. Hold syringe perpendicular to skin and insert entire needle quickly into site. Inject medication, withdraw needle and hold pressure with cotton. Area may bleed—Hold pressure. Clear fluid may leak from site—it is ok. Hold pressure. Area may bruise—don’t give another injection in that site.
GONADOTROPIN INJECTION TECHNIQUE

GONADOTOPINS (Menopur, Bravelle)

These medications are given intramuscularly (IM) or subcutaneously (SQ) daily until HCG is administered. The dosage is referred to in “AMPS” or “VIALS.” You will be told the number of AMPS/VIALS to take each day. Take this medication about the same time each EVENING. Mix the medication just prior to giving. Gonadotropins stimulate your ovaries to produce follicles-within which the eggs develop. Your ovaries will enlarge and you may experience what is often described as “twinging and pulling” in the pelvis. Other side effects you may experience include frontal headaches, mood swings, and increased vaginal mucus.

MIXING INSTRUCTIONS:
Menopur and Bravelle vials are a closed system. Therefore:

1. Pull air into the syringe to the level of “1”.
2. Inject the air into the vial of sterile water.
3. Turn the vial upside down with the needle still in the rubber dome.
4. Pull the plunger back and withdraw 1 cc of fluid from the vial.
5. Turn vial right side up and withdraw the needle.
6. Insert the needle into the first vial of powder and slowly inject all of the saline into the vial. Powder should be totally dissolved before withdrawing the needle from the vial.
7. Leave the needle in the vial and invert the vial. Withdraw all fluid from the vial by pulling back on the syringe.
8. Using the same syringe repeat steps 6 and 7 until you get to the last vial of the number prescribed.
9. Pull back on the plunger, drawing fluid from the needle into the syringe.
   Unscrew your mixing needle and replace with the injection needle. Remove any excess air bubble from the syringe.

SUBCUTANEOUS INJECTION INSTRUCTIONS: (Repronex, Bravelle)

1. Prepare an area for injection along your thigh, abdomen, or upper arms. Injection sites should be rotated between injections. Pinch skin, cleanse with alcohol, and allow to dry.
2. Hold the syringe perpendicular to the skin and insert the entire needle quickly into the site.
3. Inject the medicine, withdraw the needle, and hold pressure with a cotton ball or gauze.
4. The area may bleed or clear fluid may leak from the site. It’s okay, just hold pressure.
5. The area may bruise. If so, don’t give another injection in that site.

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*If you are using brands of gonadotropins other than the ones we have listed we will give you instructions specific to that particular brand.

**MIXING INSTRUCTIONS FOR S/C HCG (PROFASI/PREGNYL/NOVAREL)**

**Supplies:**
- Vial of Profasi (powdered)  
- Extra needle 5/8”  
- Vial of Diluent  
- Alcohol swabs  
- 3 cc syringe with needle  
- Band-Aid

**MIXING INSTRUCTIONS:**

1. Pull air into the syringe to the level of “1”.
2. Inject air into the vial of bacteriostatic water.
3. Turn the vial upside down with the needle still in the rubber dome.
4. Pull the plunger back and withdraw 1 cc of fluid from the vial.
5. Turn the vial right side up and withdraw the needle.
6. Insert the needle into the vial of powder and slowly inject the water. Agitate or shake the vial gently until all the powder is dissolved.
7. Leave the needle in the vial and invert the vial upside down. Withdraw all fluid from the vial by pulling back on the plunger of the syringe.
8. Remove the needle from the vial. The syringe now contains 1 cc of fluid mixed with 10,000 units of HCG.
9. Pull back on the plunger drawing any fluid from the needle into the syringe. Unscrew your mixing needle and replace with a new injection needle (25 gauge 5/8”). Remove any air bubbles from the syringe.

**S/C INJECTION INSTRUCTIONS:**

1. Prepare an area for the injection on the lateral aspect of either thigh. Pinch up the skin between your index finger and thumb, cleanse with alcohol, and allow time for the skin to dry.
2. Hold syringe at a 45 degree angle to the skin and insert the entire needle quickly into the thigh.
3. When ready to inject the solution, push the plunger with a slow, steady motion.
4. Gently withdraw the needle and cover the inject site with sterile cotton and apply a small amount of pressure until bleeding stops. If necessary, cover the site with a Band-Aid to prevent any blood from getting on underclothes.

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The following document is a consent form for In Vitro Fertilization. For this contract to be valid, you both must read and initial each section on the line provided. Your initials indicate that you understand and agree with each statement. If you have any questions about your consent, please have them answered before signing this consent.

Patient Name (Print Please) ______________________ Date__________
Partner Name (Print Please) ______________________ Date__________

We hereby authorize and direct the In Vitro Fertilization (IVF) team of the IVF program at Fletcher Allen Health Care, including physicians, nurses, reproductive laboratory biologists, mental health professionals, and such assistants as may be selected by them ("IVF team"), to treat us in accordance with the laboratory protocols for in vitro fertilization and embryo transfer (IVF-ET), and we hereby consent to such treatment, as outlined in this consent statement.

We understand that the purpose of our participation in the IVF Program is to achieve a viable pregnancy, resulting from the fertilization of the patient’s egg(s) with the partner’s sperm for replacement into the patient’s uterus.

We understand that in the process of in vitro fertilization, the eggs will be inseminated with sperm collected from the partner. If the egg(s) is/are fertilized and divide appropriately, the resulting embryo(s) will be transferred to the uterus. If consented to by us, some or all of the embryo(s) may be cryopreserved (frozen) for replacement in the uterus at a later date. We understand that the disposition of any cryopreserved embryo(s) will be determined solely by us, the recipient couple, as outlined within the Fletcher Allen Health Care cryopreservation consent form.

We acknowledge that we have also attended an IVF information seminar given by the IVF team, during which time the policies, procedures and risks associated with our participation in the IVF Program were explained to us as well as our participation and responsibilities. All medical options and treatments were also reviewed. We have discussed the process of IVF and embryo transfer with the members of the IVF team, and have reviewed explanatory literature of the procedures which was made available to us by the IVF team. All questions related to our participation in the program have been answered to our satisfaction.

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OVULATION INDUCTION IN PREPARATION FOR EGG RETRIEVAL

We understand that in order to produce several oocytes (eggs), the patient will need to take medications on a specified schedule to stimulate her ovaries. We also understand that it will be necessary for her to take medication (Lupron/Ganerelix) that will suppress her normal menstrual cycle so that her ovaries can be stimulated with hormones to produce eggs, and ovulation controlled with human chorionic gonadotropin (hCG) to optimize the growth of the eggs and the timing of ovulation.

We understand that Lupron is given by subcutaneous injection prior to the stimulation of the patient’s ovaries with fertility medications. We understand that Ganerelix will be used when follicular size and estrogen levels are appropriate. This will be determined by an MD. Once the ovaries are suppressed, as documented by pelvic ultrasound and serum blood hormonal studies, she will begin subcutaneous (SQ) or intramuscular (IM) hormonal injections for approximately nine to twelve days. We understand that the medication protocols used to induce ovulation are based on the patient’s past medical history and physical status.

We understand that during this treatment, the patient will be asked to have blood and/or ultrasound tests to evaluate the ovarian response to this medication. When results from blood and ultrasound monitoring reveal that mature follicles and adequate hormone values exist, the patient will receive another injection (hCG) (another concentrated form of a natural hormone) to mature the eggs and time ovulation in preparation for the surgical procedure of egg retrieval.

We acknowledge that the risks associated with transvaginal ultrasound and the drawing of her blood have been explained as follows:

A transvaginal ultrasound uses sound waves to “see” the pelvis via an ultrasound probe placed into the vagina. The sound waves allow the physician to see the uterus, the lining of the uterus, the ovaries, and the developing follicles. There are no known risks from this procedure. The patient may notice slight discomfort or pressure from the transvaginal probe. However, most women report that the ultrasound procedure is fairly comfortable. The risks associated with the blood draws are mainly bruising and soreness at the site of the puncture of the vein. Infection can occur at the blood drawing site, but is extremely rare.

We understand that despite adequate suppression of the normal menstrual cycle and appropriate stimulation with fertility medications, the patient may not achieve an adequate hormonal and ovarian response. In such circumstances, the cycle will be...
cancelled, and egg retrieval will not be performed. Before attempting another cycle, the patient will have to wait at least one cycle for the effects of ovarian stimulation to subside.

Patient______________________ Date__________
Partner______________________ Date__________

**Risks of Ovulation Induction**

We understand that there are associated risks and consequences with the use of ovulation induction medications that include, but are not limited to, the following:

1. Ovulation induction drugs will cause the ovaries to become temporarily enlarged. This may cause discomfort. Some women report the need to decrease physical activity until the discomfort improves. In very rare cases, twisting of an ovary on its blood supply may occur (ovarian torsion), causing more severe pain and necessitating surgery to correct the problem or even remove the involved ovary.

2. In approximately 2% of cycles, the ovaries may become hyperstimulated, a condition referred to as ovarian hyperstimulation syndrome (OHSS). This syndrome can usually be treated at home with bed rest and careful monitoring of symptoms. In extremely rare circumstances, ovarian hyperstimulation may become severe. This is termed severe ovarian hyperstimulation syndrome (SOHSS), and can be associated with fluid around the lungs (pleural effusion, pregnancy loss, blood clots and strokes). Hospitalization is usually required for treatment, which includes bed rest, IV fluids, and the careful monitoring of urine output, fluid and electrolyte balance, and breathing capacity. Doctors can often predict the possibility of this problem developing before it is time to administer the hormone hCG to trigger ovulation. If your risk for developing SOHSS is felt to be great, the hCG will not be given, and your cycle will be cancelled, thereby greatly reducing your risk of severe ovarian hyperstimulation. SOHSS can be a life-threatening complication, but this is extremely rare.

3. Some studies suggest a link between the use of ovulation induction drugs and ovarian cancer. These studies are not conclusive, however, because the medicine was only given to infertile women, and because infertility itself is associated with ovarian cancer. It has not been shown that there is a risk to fertile women who take any of these drugs for short periods of time.

4. Swelling, redness and slight discomfort at injection sites.

5. Allergic reactions to the medications.

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6. Fatigues, mood swings, and nausea, which may be attributed to higher levels of estrogen.

Finally, as part of the ovulation induction process, we are aware that the patient will be asked to abstain from strenuous exercise and sexual activity during a specific time period of the treatment cycle.

Patient______________________ Date__________
Partner______________________ Date__________

**EGG RETRIEVAL**

We understand that when ultrasound findings and blood hormone levels reveal that the patient's eggs are ready for collection, she will receive an injection of human chorionic gonadotropin (hCG) for proper timing of the egg retrieval. The retrieval will be scheduled approximately 34 to 36 hours after the administration of the hCG.

We recognize that egg retrieval utilizes a vaginal ultrasound probe to guide a needle through the vaginal wall into the ovary. This procedure is performed under sterile conditions in the Ambulatory Care Center (ACC) at FAHC, and will require the use of spinal anesthesia or intravenous analgesia under the supervision of an anesthesiologist. The procedure lasts for approximately one hour.

Following the retrieval, we understand that the patient must stay in the recovery area for at least two to three hours before getting dressed and being discharged. We understand that one of the consequences of the procedure may be light to moderate amounts of vaginal bleeding. We understand that the medications used during the retrieval may make her feel drowsy. We further understand that she will be observed by the ACC personnel following the procedure to ensure that there are no observable abnormal effects from the medication.

Finally, she is aware that because of the effects of the medication, the patient should not drive on the day of her egg retrieval.

Patient______________________ Date__________
Partner______________________ Date__________

**Risks of Egg Retrieval**

The risks involved in egg retrieval are those associated with any minor surgical procedure, including infection and risk of injury to nearby organs, including bowel, blood vessels, or other structures. There is also a possible risk that the needle stick used to obtain the eggs from the ovaries might cause bleeding. Ovarian bleeding or rupture rarely occurs, but may lead to hospitalization for observation, or surgery to control bleeding or to repair or remove the ovary. Every measure will be taken to prevent these occurrences, and the possibility of occurrence is very small. Theoretically, there could be a potential loss of fertility resulting from having a complication related to the retrieval. There is also the remote possibility that surgery may be
necessary to control a pelvic infection, and could result in the loss of one or both ovaries, fallopian tube(s) and uterus.

Patient______________________ Date__________
Partner______________________ Date__________

EMBRYO TRANSFER

We understand the when the IVF team determines that the ovulatory process is at the appropriate stage to obtain as many eggs as possible from the patient’s ovaries, she will be admitted to Fletcher Allen Health Care for a transvaginal ultrasound-guided retrieval. Following the egg retrieval, the eggs will be inseminated with the sperm collected from the patient’s partner or other appropriate source. After two to six days, the appropriate number of any resulting embryos will be transferred into the uterus using a specialized soft, flexible catheter, which is passed through the cervix.

We also understand that any of the following may occur which would prevent the successful completion of these procedures and preclude the establishment of a pregnancy.

1. There may be a suboptimal response to the ovulation induction medications.
2. The attempt to obtain the egg(s) may be unsuccessful because of undetected ovulation.
3. The egg(s) may not be normal.
4. The patient’s partner may be unable to produce a specimen.
5. Fertilization may not occur or may be abnormal in some or all of the eggs.
6. Cleavage or cell division of the fertilized egg(s) may not occur.
7. The embryo may not develop normally.
8. The embryo transfer may be technically difficult.
9. Implantation of the fertilized egg(s) may not occur.
10. A laboratory accident may result in loss or damage to the egg(s) or embryo(s).

Patient______________________ Date__________
Partner______________________ Date__________

POTENTIAL CONSEQUENCES RESULTING FROM TRANSFER OF MULTIPLE EMBRYOS

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We understand that the number of embryos returned to the uterus is based upon a number of factors, including maternal age and embryo quality. This number reflects an effort to optimize the chance of pregnancy while minimizing the risk of high order multiple gestates. We also understand that in most cases, two or more embryos will be returned to the uterus.

If multiple embryos are transferred, multiple pregnancy can occur up to and sometimes exceeding the number of embryos transferred. There are many potential obstetrical, physical and social consequences that may result from multiple pregnancy. These include, but are not limited to, the following:

1. Maternal
   a. Possible increased risk of pregnancy-related diseases, such as gestational diabetes.
   b. Possible increased risk of exacerbating preexisting medical disease, sometimes irreversibly.
   c. Increased risk of birthing accidents, such as rupture of umbilical cord, separation of the placenta, low lying placenta, and uterine rupture.
   d. Increased risk of preterm labor, which increases with the number of fetuses in the uterus.
   e. Increased risk of the necessity for delivery by cesarian section.
   f. Increased vulnerability to emotional stress reaction(s).

2. Fetal
   a. Increased risk of prematurity, low birth weight, umbilical cord accidents, death of one or more fetuses.
   b. Increased risk of prolonged hospitalization of one or more babies.
   c. Long-term health problems due to prematurity, including, but not limited to, severe lung disease or neurological disease (brain damage).

Patient______________________ Date__________
Partner______________________ Date__________

MULTI FETAL REDUCTION OPTION

We acknowledge that we have been advised of the risk of multiple gestation and its potential medical impact. We understand that in the event there are three, four, or more implanted embryos, multi fetal reduction may be recommended to us in order to preserve the health of the mother and/or fetus(es). In this context, multi fetal reduction has been discussed with us. We understand that multi fetal reduction involves terminating one or more of the fetuses, and we are aware of our option to pursue this course of action, if appropriate.

Further, we acknowledge that if multi fetal reduction is an unacceptable option to us, we have discussed with the IVF team the maximum number of embryos to be transferred in order to meet the goals of

(a) optimizing the achievement of pregnancy, and
(b) reducing the risks of multiple gestation to both the mother and the remaining fetus(es).

Patient______________________ Date__________

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BIRTH DEFECTS

We understand that the incidence of major birth defects in singleton pregnancies is approximately two percent in the general population. Further, we understand that even with the most precise screening methods possible, there is a chance that a pregnancy resulting from reproductive technology, as in any pregnancy, can result in a child with birth defects, medical problems, learning disability, handicaps, cerebral palsy, and other unforeseen difficulties. Some of these problems can arise from genetic abnormalities that cannot be detected with modern screening tests. Some of them can result from birth accidents and illness during pregnancy. We have also been informed that results to date of IVF, GIFT, and other assisted reproductive technologies (ART) have shown no increased risk of abnormal infants when compared to a spontaneous pregnancy. We will not bring any claim against Fletcher Allen Health Care if we conceive a child with such abnormalities or difficulties, and understand that our agreement is for the benefit of Fletcher Allen Health Care.

OWNERSHIP RIGHTS FOR EMBRYOS RESULTING FROM IVF

We understand that once the egg(s) is/are removed from the patient, they and any resulting embryo(s) are our sole responsibility. We understand and agree that we are legally responsible for the resulting embryo(s). As documented in “Consent to Destroy, Freeze or Donate Extra Eggs or Embryos”, we have agreed to make appropriate plans for any embryos not transferred to the uterus at the time of the initial IVF cycle.

OFFSPRING RESULTING FROM IVF

We understand that any offspring resulting from IVF are our children, and we specifically assume all legal rights and obligations normally associated with having offspring. We understand and agree that we are fully responsible for any and all offspring, regardless of the outcome of the pregnancy.

We acknowledge that the recipient couple is fully responsible for any and all offspring, regardless of the outcome of the pregnancy.

CONFIDENTIALITY

We have been assured that all information about us obtained during this treatment will be handled confidentially and neither our identity nor specific medical or psychological details will be

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voluntarily revealed without our consent. Specific medical details may be revealed in professional publications as long as our identity is concealed.

Patient______________________ Date__________
Partner______________________ Date__________

FINANCIAL RESPONSIBILITY

We understand that we are responsible for charges incurred as part of the IVF procedure, whether or not there is a successful procedure. This includes, but is not limited to, the physician, laboratory, and hospital charges, as well as administrative charges incurred by Fletcher Allen Health Care. Our insurance may or may not cover all of these charges, but we will be responsible for any unpaid monies. We understand that we are financially responsible for all costs associated with any resulting pregnancy.

We understand that insurance coverage for any or all of the aforementioned procedures may not be available, and we will be personally responsible for the expenses of the treatment. These expenses may consist of hospital charges, laboratory charges, and/or physician professional fees.

Patient______________________ Date__________
Partner______________________ Date__________
CONSENT TO IVF PROGRAM PARTICIPATION

My request and authorization for participation in the Fletcher Allen Health Care In Vitro Fertilization Program is purely voluntary. I understand that I may revoke this consent at any time prior to the removal of eggs from my body, and that my present or future care at Fletcher Allen Health Care will not be in any way affected by that decision. I agree that this consent may only be revoked in a signed, written submission delivered to a member of the IVF team. This consent extends to Fletcher Allen Health Care and the IVF team to whom I have entrusted my care and others assisting, associated with, or designated by those parties.

I certify that I have read and fully understand this Informed Consent statement, which has been preceded by both a written explanation and a verbal explanation by a member(s) of the IVF team, and that the explanations referred to are fully understood by me. I have had the opportunity to ask the IVF team any questions, and am satisfied with the answers provided. I have no further questions, and fully intend to be legally bound by my consent to the procedures outlined in this Informed Consent statement, as evidenced by my signature below.

_____________________________________  _________________ ___________
Patient signature     Date   Time

_____________________________________  _________________ ___________
Partner signature     Date    Time

_____________________________________  _________________ ___________
(Signature of person obtaining Informed consent)     Date    Time

VERMONT CENTER FOR REPRODUCTIVE MEDICINE
Women’s Health Care Service
Fletcher Allen Health Care, Inc.
Peter R. Casson, MD – IVF Medical Director

Updated February 2009
Supplement to Informed Consent for In Vitro Fertilization
Intracytoplasmic Sperm Injection

Intracytoplasmic sperm injection (ICSI) is a modification of in vitro fertilization (IVF). This procedure is performed in couples who would otherwise be unable or unlikely to achieve fertilization alone. ICSI may be recommended in couples who have experienced fertilization failure in an IVF cycle or when infertility is due to male factor. Male factor infertility or abnormal sperm function may be due to very low sperm counts, low sperm motility, or antisperm antibodies. It may also be due to abnormal development of the testes, obstruction of the vas deferens, injury to the testicle, chemotherapy, radiation therapy, abnormal hormone levels, or problems with the chromosome that controls the development of the sperm.

In standard IVF, fertilization occurs spontaneously when the egg and sperm are mixed together in a dish. With ICSI, fertilization is achieved by injecting a single sperm into a single egg. ICSI bypasses both the need to have the sperm swim through the reproductive tract to reach the egg and the need to have the sperm penetrate the egg. An ICSI cycle is identical to the IVF cycle until the fertilization step. Insrmination with ICSI can be done with fresh or frozen sperm from an ejaculate, aspirated from the epididymis or extracted directly from a testicular biopsy. The embryologist then selects a single sperm and using a specialized needle to penetrate the egg membrane, the sperm is injected into the egg. From this point on the procedure continues as in a standard IVF cycle. The resulting embryos are grown in the laboratory for 3 to 5 days before transfer to the uterus.

Potential risks and complications of the ICSI procedure include all of the risks associated with the IVF procedure as described in the “Informed Consent for In Vitro Fertilization and Embryo Transfer.” Potential risks specific to the procedure of ICSI are listed below:

1. **Damage to the oocytes**: During the ICSI procedure, each egg is handled individually. Some of the eggs might be damaged during the handling process and will not be available for fertilization. Some eggs may have membranes (cell walls) which are difficult to pierce with the needle. This may result in egg damage that will prevent the egg from dividing (cleaving) and progressing to a normal embryo. Overall, it is expected that at least one half (50%) of the eggs will fertilize.

2. **Cleavage Arrest**: After the sperm is injected into the egg, the fertilized egg is cultured for three or five more days. During this time the fertilized egg will divide and grow into an embryo with multiple cells. In both ICSI and non-ICSI IVF cycles the fertilized egg may fail to divide or the embryo may arrest at an early stage of development. Of the eggs that fertilize, approximately 8/10 or 80% will go on to divide (cleave). These rates may be lower in some women because of poor quality, advanced maternal age or poor response to gonadotropin stimulation. Pregnancy rates following ICSI cycles have been reported to be between 20% and 40%. Your physicians will give you the current rates for IVF/ICSI. Fertilization and implantation are not guaranteed for any couple and pregnancy may not be established even with ICSI.

3. **Sperm**: It is possible that there will not be enough sperm recovered for the ICSI fertilization. Sperm counts in men who are candidates for ICSI are very low and there may not be enough living sperm available for the ICSI procedure on the day of retrieval. The risk is higher in men where additional procedures such as MESA (microsurgical epididymal sperm aspiration) or TESA (testicular sperm aspiration) are required.

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4. **Chromosomal Abnormalities:** ICSI, first introduced in 1992, is still a new procedure. We are continuing to learn about the offspring of ICSI-related pregnancies. Some men who have very low sperm counts or abnormal sperm function may have chromosomal abnormalities. Researchers have identified a higher rate of microdeletions of the Y-chromosome (missing very small segments of DNA) and other chromosomal problems in some forms of male factor infertility. It is possible that these same chromosomal defects could be passed on to the offspring of these men. This may result in a male child experiencing problems with the development of sperm, potentially having the same form of infertility as the father. Men with some forms of infertility may be carriers of cystic fibrosis; your physician may offer screening for this gene to determine the risk of having a child with cystic fibrosis. Currently there is no way to identify sperm that may be carrying these defects. Tests are available to identify some of these microdeletions in your chromosomes, and embryos can be diagnosed as having or carrying Cystic Fibrosis before implantation. If you are interested in being tested, your physician can give you more information.

5. **Birth Defects:** ICSI is a new procedure. Although no evidence exists to demonstrate long term risk for the children born following ICSI procedures, we cannot eliminate this possibility. The risk of birth defects has not been shown higher in children born after the ICSI procedure than in the general population. The possibility of birth defects because of the ICSI procedure can not be completely ruled out. Birth defects could be minor or major such as chromosomal abnormalities, mental or psychological impairment, missing organs, malformed limbs or spine.

We, _____________________________ and ____________________________ request and authorize the In Vitro Fertilization program at Fletcher Allen Health Care, Inc., to use Intracytoplasmic Sperm Injection to achieve fertilization in an IVF cycle. We have read and understand the risks and benefits of the procedure as outlined in the above description. We have also read and signed the “Informed Consent for In Vitro Fertilization and Embryo Transfer.”

We understand that we may revoke this consent at any time prior to the removal of eggs from the patient’s body, and that our present and future care at Fletcher Allen Health Care, Inc., will not be in any way affected by that decision. We agree that this consent may only be revoked in a signed, written submission delivered to a member of the IVF team. This consent extends to Fletcher Allen Health Care, Inc., and the IVF team to whom we have entrusted our care and any others assisting, associated with or designated by those parties.

We certify that we have read and fully understand this Informed Consent statement, which has been preceded both by a written explanation and a verbal explanation by a member(s) of the IVF team, and that the explanations referred to, are fully understood by us. We have had the opportunity to ask the IVF team questions and are satisfied with the answers provided. We have no further questions and fully intend to be legally bound by our consent to the procedures outlined in this Informed Consent statement, as evidenced by our signatures below.

_______________________________________   _______________

Patient Signature         Date

Time

Updated February 2009
Information Concerning the IVF Procedure and Consent to Destroy, Freeze or Donate Extra Eggs or Embryos

Patient Name: ______________________  Partner Name: ______________________

In Vitro Fertilization (IVF) is a new area in which legal principles and requirements have not been firmly established. As a participant in this process, you should be informed to the extent possible concerning all legal as well as medical aspects of the procedure. You should feel free to consult your own attorney. The following brief overview is not intended as a comprehensive analysis, but to provide you with basic information. A consent form is included should you decide to participate in the IVF process. Before beginning the IVF process, you should read and understand all information contained in this form.

Informational Overview

To assist infertile patients to procreate, the IVF procedure joins in an incubator a woman’s egg and a man’s sperm. When the desired conception occurs, the embryo is returned (transferred) to the womb (uterus) for continued development. This transfer of an embryo can be done within days of conception or delayed for years when the embryo is frozen by the process called cryopreservation. When the egg and sperm of the woman and man are united outside the body and the resulting embryo implants in the woman, that embryo has the same legal relationship to the mother and father as any other embryo. The primary legal problem involved in IVF is raised by the fact that, in the process of obtaining and inseminating eggs from the female, more eggs or embryos are frequently obtained than may be safely transferred to the uterus at one time. Because of this we have established that no more than four (4) inseminated eggs, or embryos, will be transferred in order to avoid an increased chance of multiple pregnancies. Therefore, some disposition must be made of any extra eggs or embryos not transferred to the woman.

First, you must decide whether to limit the number of eggs which are inseminated with sperm to avoid the development of more embryos that can be immediately transferred. Second, you must decide what options you wish to exercise regarding disposition of any extra eggs or embryos. Those options are as follows:

A. Eggs – destruction or donation
B. Embryos – destruction, donation, or freezing

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Each of the options is described in the following paragraphs. After you understand all options available to you, you will be asked to consent to one or more of the possibilities.

1. **Limitation of Number of Eggs Inseminated**: This option avoids the development of extra non-transferred embryos. If when eggs are obtained at the time of the IVF procedure, and all eggs are inseminated with sperm, there is a chance that more embryos will develop than can be safely transferred to the uterus at one time. To avoid having to destroy or freeze extra embryos, you have the option to request that the IVF team inseminate a limited number of eggs. (Because not all eggs fertilize, should you select this route, you may end up with zero or less than the desired number embryos to transfer to the uterus.)

   a. **Destruction of Eggs** - Eggs, which are not inseminated, can be destroyed in accordance with standard procedures for the destruction of human tissues.

   b. **Donation of Eggs** – Eggs, which are not inseminated, can be donated for embryologist training.

2. **Disposal of Unfertilized or Immature Eggs**: If you do not limit the number of eggs inseminated, all mature eggs obtained by the IVF procedure will be inseminated. However, it is possible to have eggs that do not fertilize or create embryos. You must elect to destroy or donate unfertilized or immature eggs.

   a. **Destruction of Unfertilized or Immature Eggs** – Eggs, which do not fertilize or are deemed immature, can be destroyed in accordance with standard procedures for the destruction of human tissues.

   b. **Donation of Unfertilized or Immature Eggs** – Eggs, which do not fertilize or are deemed immature, can be donated for embryologist training.

3. **Disposal of Additional Embryos**: If you do not limit the number of eggs inseminated, all eggs obtained by the IVF procedure will be fertilized and some additional embryos, which cannot be immediately transferred, may result. You must elect to destroy, donate or freeze any such extra embryos.

   a. **Destruction of Extra Embryos** – Under this option, following the transfer of the appropriate number of embryos, the extra embryos will be disposed of by the IVF team in accordance with the destruction of human tissue.

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b. **Donation of Embryos** – Embryos may be donated for embryologist training. While we do not provide donation to another couple, we can assist in shipment of embryos to an outside facility.

c. **Freezing** – An alternative to destruction or donation of the extra embryos is to preserve them by freezing. Frozen embryos can be stored at a very low temperature for years. Risks of freezing the embryos are not known. We cannot guarantee that the frozen and thawed embryos will have as good a chance to produce a pregnancy as embryos that are not frozen. Frozen embryos may be damaged during storage or destroyed by unforeseeable problems. We cannot guarantee that frozen embryos will be available for embryo transfer.

The potential benefit of freezing the extra embryos obtained from the first attempt at IVF arises when the first attempt fails to establish a pregnancy. Thawed embryos can then be replaced in another cycle, increasing the chance of a pregnancy following a single egg retrieval. The gonadotropins would not have to be taken for the frozen attempt and the embryos could be transferred during a medicated cycle or a natural menstrual cycle. In addition, if all goes well and you have a child from the first attempt, and you decide to try again for more children, then your embryos may be used for this attempt at a later date.

If you elect to freeze any extra embryos, we will request and respect your wishes (within ethical and legal limits) as to what to do later with the frozen embryos. Your ongoing options concerning such frozen embryos are:

1. Thaw and transfer the embryos according to the IVF procedure.
2. Destruction as described above.
3. Donation as described above.

You are free to exercise these options at any point in time after the embryos are frozen. **You must keep us informed of your current address and we will contact you by registered mail at least once each calendar year to determine which option you wish to select.** At that time you will receive a bill for the yearly storage fee for frozen embryos.

- If you wish to maintain embryos in storage, this bill must be paid each year.
- If you do not remain current or your storage fees are not paid for greater than two (2) years then your embryos will be disposed of by the IVF team in accordance with the destruction of human tissue.
- If four years have elapsed since the original date of freezing then your options are limited to those described in 1, 2, or 3 above.
- If you do not choose an option at this time, then the embryos will be disposed of by the IVF team in accordance with Fletcher Allen Health Care policy for the destruction of human tissue.

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In the event of the death of only one partner (man or woman), the frozen embryos will become the responsibility of the remaining partner. In the event of separation or divorce, it is the responsibility of both partners to reach an agreement regarding the disposition of frozen embryos.

The clinic must be informed in writing of any changes which affect the future use of frozen embryos. It is also the responsibility of the patient and her partner to inform the clinic of any address changes.
Consent Form

I have read and understand the above information concerning the IVF procedure. I have been informed verbally about the procedures, I have had a chance to ask questions and have voluntarily decided to participate in the program and consent to the procedure as described. I specifically understand that I will be making a decision concerning the disposition of embryos that are not replaced during the initial IVF procedure and authorize Women’s Health Care Service and the physicians involved in this procedure to:

(Choose either option A or B and initial your choices as indicated.)

A. Limit the number of eggs to be inseminated per IVF attempt.

Any additional eggs collected which are not inseminated will be (choose and initial one option):

- Destroyed, as described above.
- Donated, as described above.

B. Inseminate all mature eggs obtained.

Any eggs that do not fertilize and are deemed immature will be (choose and initial one option):

- Destroyed, as described above.
- Donated, as described above.

Any embryos which are not immediately transferred will be (choose and initial one option):

- Destroyed, as described above.
- Donated, as described above.
- Frozen, as described above, in which case I will be given a yearly option regarding disposition of these embryos.
**Additional Consent Items to Patients Choosing to Freeze Embryos**

Under special circumstances, death or extenuating circumstances may prevent us from obtaining your consent regarding the disposition of your frozen embryos. Therefore, if you choose to freeze your embryos you will be asked to consent to the following:

*Please initial one option for C, D and E.*

**C.** One of the two options in the event of both partners' death. These options are:

- [ ] 1. Destruction
- [ ] 2. Donation

**D.** One of the two options in the event of divorce are:

- [ ] 1. Destruction
- [ ] 2. Donation

**E.** One of the two options if we are unable to locate you and/or you have failed to exercise your options within two consecutive years since last contact.

- [ ] 1. Destruction
- [ ] 2. Donation

________________________  ______________________________
Date      Time    Date      Time

________________________
Signature of Patient

________________________
Signature of spouse or partner

________________________
Signature of Witness
CONSENT FOR ASSISTED HATCHING

Assisted hatching (AH) is a modification of in vitro fertilization (IVF). It is performed on the fresh or frozen embryos of couples who are deemed at high risk for not obtaining a pregnancy, despite good embryo quality. It is considered in couples where the female partner is over 38 years of age, or where a previous IVF cycle did not result in a pregnancy, despite good quality embryos, independent of the woman’s age. Finally, the embryologists may have noted certain embryo qualities in a previous cycle (“thickened zona pellucida”) that may reduce embryo implantation and which assisted hatching can help overcome.

Oocytes are single cells inside a rubbery protein eggshell called the zona pellucida. With both spontaneous fertilization and fertilization at IVF (assisted with ICSI or otherwise) the sperm travels through the zona pellucida and combines with the egg inside, forming an embryo. This embryo subsequently divides, while still inside the zona pellucida; at the time of embryo transfer, the embryos still have this “shell”. Just prior to implanting in the wall of the uterus, the embryo hatches from the zona pellucida. In some patients, particularly with advancing maternal age, this hatching process is thought to be impaired.

Assisted hatching is a process where the embryologist actually creates a hole in the zona pellucida to facilitate the hatching process once the embryo transfer is completed. This is done mechanically (with a type of microscopic knife), or with a jet of fluid that dissolves a hole in this shell. Alternately, a laser beam is used for this procedure.

The clinical results with assisted hatching are not entirely clear. There is reasonable evidence that the procedure may slightly improve outcomes in certain subgroups of patients, as noted above. There is of course the possibility that in the future, further studies in this area may show AH has no benefits, and indeed, may be detrimental.

Possible risks and complications of assisted hatching include but are not limited to the following:

1. **Embryo damage/Reduces pregnancy rate**: The actual process may damage the embryo, reducing its viability and thus its ability to result in a pregnancy, resulting in a failed IVF cycle.
2. **Increased incidence of identical twins**: There is some evidence that assisted hatching increases the chance that the embryo will split into two identical parts—identical twins. Theoretically, if the split occurred late this might result in conjoined twins, although this has never been seen with this procedure. However, if identical twinning did occur after embryo transfer it could possibly result in triplets, quadruplets or higher order pregnancies, depending on the number of embryos replaced. As outlined in the consent form for IVF, multiple pregnancies have a whole host of complications.
3. **Birth defects**: Any manipulation of the embryo has the theoretical potential of increasing the risk of birth defects. While this has not been shown with AH, the possibility does exist that this may be a problem in the future.
We, _____________________________ and ____________________________ request and authorize the In Vitro Fertilization program at Fletcher Allen Health Care, Inc., to perform assisted hatching on our embryos. We have read and understand the risks and benefits of the procedure as outlined in the above description. We have also read and signed the “Informed Consent for In Vitro Fertilization and Embryo Transfer.”

We understand that we may revoke this consent at any time prior to the actual time of AH, and that our present and future care at Fletcher Allen Health Care, Inc., will not be in any way affected by that decision. We agree that this consent may only be revoked by written submission to a member of the IVF team. This consent extends to Fletcher Allen Health Care, Inc., and the IVF team to whom we have entrusted our care and any others assisting, associated with or designated by those parties.

We certify that we have read and fully understand this informed consent document, and have had all our questions satisfactorily addressed by a member or members of the IVF team. We have no further questions and fully intend to be legally bound by our consent to the procedures outlined in this informed consent document, as evidenced by our signatures below.

Patient Signature ___________________________  Date __________  Time __________

Partner/Spouse Signature ___________________________  Date __________  Time __________

Witness Signature ___________________________  __________  __________
FREQUENTLY ASKED QUESTIONS
DURING THE IVF PROCESS

Q. I thought I was going to see my own doctor throughout this process of IVF and want him/her to do my IVF retrieval and transfer. Why can’t my doctor do all of my ultrasounds and procedures?
A. At the Vermont Center for Reproductive Medicine we work as a team. All of the physicians and nurses on our team are involved in your care and are able to assist you with any part of the IVF process. If you have specific concerns regarding your treatment we will communicate this to your physician. All of the physicians on our team are aware of your current status and are happy to assist you with any part of the process.

Q. I have been prescribed oral contraceptives prior to my IVF cycle. If I have the diagnosis of infertility, why do I need to use a form of barrier contraception for the first two weeks on the pills?
A. In some types of infertility there is always a chance that conception could occur. If you were to become pregnant while taking IVF medications it is unknown what effects these medications would have on a fetus.

Q. I was seen for my baseline visit today and I have a large ovarian cyst. What is going to happen now? Can I still proceed with my IVF cycle?
A. We may not be able to proceed with your IVF cycle if you have a large ovarian cyst. Ovarian cysts often resolve on their own, especially after taking Lupron for an extended period of time. Your doctor will determine what the appropriate course of action will be for you. If the cyst resolves, it is possible to proceed with your IVF cycle however, your cycle may be delayed and not start on the original date that was planned.

Q. There are several appointments involved in the IVF process. Does my husband need to attend all the appointments as well?
A. We understand that getting time off from work is very stressful for couples. There are only a few appointments that husbands are required to attend. These appointments include:
1. Appointment to sign consents.
2. IVF Retrieval day semen collection.
All other appointments involve the female partner only. Husbands should feel welcome to attend all appointments but it is not a requirement.

Q. I am two days away from my blood pregnancy test and I started my period. I know I am not pregnant. Why do I have to have my blood drawn?
A. This is a statement that is commonly voiced by women who have gone through an IVF cycle. 20-30% of women have vaginal bleeding early in pregnancy. It is very important to confirm the results of your pregnancy test before stopping your progesterone. It is possible to have vaginal bleeding at the time your period is due and still have a healthy pregnancy!

Q. The nurse just called me with my blood pregnancy test results. The number she gave me seems high. What does this mean? Could I be having twins?
A. A Beta HCG level (measurement of the pregnancy hormone in your bloodstream) has many variations. There is no way to determine a multiple pregnancy solely on your blood result. This blood test is a comparative test. We will draw a BHCG 12 days after your embryo transfer and then again in 48 hours. We hope to see at least a 50% rise in the two numbers. If we see this rise, the next step will most likely be to schedule your ultrasound. At the ultrasound we will be better able to determine how many fetuses are in the uterus.

Q. It is a Saturday and I am out of my Progesterone Vaginal Suppositories. What do I do now?
A. When the nurses order your medications, we many times will add refills to you original order. Please call your pharmacy and ask if you have refills. If not, you can always contact one of the doctors on call to have your prescription called in. It is important to keep track of the supply you have of all your medications and to notify the nurse ahead of time that more medications need to be ordered. This will avoid undue stress on you and your partner during an already stressful process.

Q. When I place the progesterone suppository into my vagina it seems like it is all dripping out. Am I getting enough medication or not?
A. Progesterone Vaginal Suppositories are very messy. You may want to wear a panty liner to avoid soiling your underclothes. The suppositories melt and are absorbed in the vagina very quickly. Even though it seems like all of the medication is leaking out, rest assured that you are getting just what you need.

Q. Is it ok to have intercourse during my IVF cycle?
A. There are times during your IVF cycle when it is ok to have intercourse, and times when it is not. It is ok to have intercourse during the stimulation process of the IVF cycle. When the retrieval is scheduled, the male should not have an ejaculation from the day of the HCG until the retrieval. Once the retrieval has occurred, you should refrain from intercourse and orgasm until the results of your pregnancy test are known.

Q. I am already taking a generic multivitamin. Do I have to switch to a pre-natal vitamin and when should I begin it?
A. The current recommendation is to begin at least 800-1000 micrograms of Folic Acid prior to conception to aid in the prevention of neural tube defects. We recommend that you begin a pre-natal vitamin with 1 milligram of Folic acid at the same time you begin your Lupron.