INFORMED CONSENT FOR ADMINISTRATION OF GONADOTROPINS

FERTINEX (FSH), GONAL-F, FOLLISTIM, METRODIN, REPRONEX, PERGONAL (hMG), CLOMIPHENE CITRATE AND HUMAN CHORIONIC GONODOTROPIN (HCG)

I understand that the medications Clomiphene Citrate (Clomid, Scrophene), Fertinex, Follistim, hMG, Gonal-F, Pergonal, and Repronex may have any of the following side effects:

1. Injection site bruising.
2. Pain at the injection site.
3. Rare but possible infection at the injection site.
4. Abnormal discomfort when the ovaries enlarge.
5. Hyperstimulation syndrome may be caused by the production of a very large number of ovarian follicles. The symptoms are significant abdominal distension and discomfort, and can lead to hospitalization.
6. Decreased chance of pregnancy can be caused by production of inadequate number of ovarian follicles.
7. Mood swings (which can include but are not limited to irritability and increasing emotional sensitivity).
8. Increased chance of multiple pregnancy – conception of twins, triplets or multiples of more than three. With gonadotropins, the chance of multiple pregnancy is 20-25%.
9. 10% chance of multiple pregnancy can be caused by Clomiphene Citrate.

I understand that whenever a woman receives fertility medications to induce ovulation, she may have multiple pregnancies. I have been advised and recommended by my physician to consider and go through selective reduction of pregnancy if I was to conceive more than three pregnancies.

I also understand that the risks listed above are all known risks of gonadotropins. There is also a possible risk of fertility drug usage and ovarian cancer. Detailed information regarding this risk has been made available to me.

I, _____ (female patient receiving the gonadotropins – please print name) have been informed that the ovulation inducing drugs I will receive during the process of my infertility treatment are to stimulate growth and maturation of eggs and follicles of the ovary. I have been given information about the medication and side effects of Clomiphene Citrate, FSH, hCG, and hMG. I have also read and fully understand this Consent Form, and have had the opportunity to have any questions answered. I voluntarily sign this Consent Form with the knowledge that a copy is available to me at my request.

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE
WITNESS NAME (PRINT)	WITNESS SIGNATURE	DATE