GONADOTROPIN CONSENT FORM

I voluntarily request DFW Fertility Associates, including physicians, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as infertility.

I, ______________________________________, hereby consent to the administration of Clomiphene citrate, Letrozole, Follistim, Gonal F, and/or other gonadotropins, hCG and possibly Lupron, Antagon or Cetrotide to me in the dosage and frequency that his judgement may dictate in order to increase the possibility that I might become pregnant.

I understand that gonadotropins have known adverse effects, such as:

1. Ovarian enlargement.
2. Visual disturbances.
3. Multiple pregnancy.
4. Ovarian hyperstimulation requiring hospitalization.
5. Twisting or rupture of the ovary necessitating a laparotomy and removal of the ovary and/or blood transfusion.
6. Water retention and electrolyte imbalance.
7. Increased coagulability of blood and possible pulmonary embolism or stroke.
8. Possible association with an increased risk of ovarian cancer.
9. Disability or death.

I also understand that Lupron is given to suppress ovarian function by inhibiting pituitary release of gonadotropins and may cause a transient menopausal state, headaches, palpitations, hot flushes, irritability, and may profoundly suppress ovarian function.

I understand that any pregnancy may produce an infant with a birth defect; this includes any pregnancy that results from the above-described therapy. Birth defects can be minor (such as an extra rib) or major (such as a defect in the development of the heart, lungs or kidneys that is incompatible with life). I understand and accept the risks involved in the use of clomiphene citrate, Letrozole, Follistim, Gonal F, Repronex, Menopur and/or Bravelle and hCG to increase my chances of becoming pregnant. We understand that attempts to induce ovulation by the use of fertility medications may need to be abandoned due to poor follicular development, overstimulation or an abnormal hormonal pattern at the discretion of the physician.

I have been provided an opportunity to ask questions and such questions have been answered to my satisfaction. I understand I may continue to ask questions relating to this therapy at any time. This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

We hereby release the physician from any and all liability of injury or damages to ourselves arising out of the use of the ovulation induction medications described above, not limited to ovarian hyperstimulation syndrome, multiple pregnancy, possible hospitalization, possible loss of ovaries or pelvic infection. We understand that the long-term effects of the use of gonadotropins are not known at this time.

Patient: ________________________________ Signature ___________________________________

Witness: _______________________________ Signature ___________________________________

Date: _______________________________________