

# REPRODUCTIVE RESOURCE CENTER

*20 years of Innovation*

## **CONSENT TO TREATMENT FOR GONADOTROPIN THERAPY**

1. Gonadotropin therapy has been recommended for me.
2. The nature and purpose of the medication have been fully explained to me. The potential benefits and risks of the treatment, the likely result without treatment, and the available alternatives have also been explained to me.
3. In summary, I understand:
  - a) The purpose of the gonadotropin therapy is to achieve pregnancy when other methods have failed. Gonadotropins work by stimulating the ovaries to develop multiple follicles which contain eggs.
  - b) I will be administering gonadotropin by self-injection or by a person designated by me. The injections will be administered for approximately 7-14 days during the therapy month, depending on my response to the medication. During the course of therapy, I will be monitored by ultrasound and evaluation of blood estradiol levels.
  - c) Risks include severe hyperstimulation of the ovaries (2% chance in any cycle) and multiple gestation pregnancies (20-25% chance of twin pregnancy, 1-5% chance of triplet pregnancy and a rarer chance of a higher order multiple pregnancy). In very rare cases, hyperstimulation could lead to very enlarged ovaries and an increased susceptibility to develop blood clots necessitating hospitalization. In extraordinarily rare cases, hyperstimulation could lead to the surgical removal of an ovary or death. The risks of fetal anomalies are presently thought to be the same as pregnancies achieved without ovulation induction. The risk of miscarriage may be slightly higher than in pregnancies achieved without ovulation induction.
4. I also understand that with any procedure, there is always the possibility of an unexpected complication, and that no guarantees or promises can be made concerning the results of any procedure or treatment.
5. Additional comments, if any:
6. I hereby consent to the course of gonadotropin therapy recommended for me and understand and accept the above explanation and risks associated with undergoing this treatment.

Patient Name: \_\_\_\_\_  
(please print)

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_  
(please print)

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_