Female Patient Name: _______________________ Social Security #: _____________

Karande & Associates, S.C. doing business as

INVIA FERTILITY SPECIALISTS

CONSENT TO THE USE OF FERTILITY ENHANCING MEDICATIONS

I understand that the potential risks and consequences of the use of fertility enhancing drugs include, but are not limited to:

1. Hyperstimulation Syndrome, which, in general, manifests itself as enlarged, tender ovaries with bloating.
2. The chance of multiple pregnancy ranging from 5-25% depending upon the type of drug used and my medical diagnosis.
3. A potential long-term risk of ovarian cancer, which is still under investigation. Further information about this risk is described in a statement from the American Society of Reproductive Medicine (formerly the American Fertility Society).
4. Allergic reactions.
5. Other risks not listed here may also be possible.

I also understand and agree that these drugs will require self-administration, usually by injections, and that I am responsible to take these drugs precisely as directed by the staff of INVIA FERTILITY SPECIALISTS. I understand that the use of these drugs requires close office monitoring, including the use of ultrasounds and blood tests as determined by the staff of INVIA FERTILITY SPECIALISTS. I agree to confirm the self-administration of these drugs as required and acknowledge that I have been informed that INVIA FERTILITY SPECIALISTS's clinical staff are available 24 hours a day, 7 days a week should an emergency consultation be needed to confirm a drug dose, instructions or administration. I understand that my adherence to the instructions of the clinical staff is essential for the safe use of these medications.

I acknowledge and agree that the use of fertility drugs is a dynamic aspect of medicine and that, from time to time, specific drugs may be used or discontinued based on newly published scientific information. I also acknowledge that it may be necessary to introduce certain drugs alone or in combination with established regimens of treatment selectively to certain groups of patients to determine their effectiveness in producing ovulation and/or pregnancy. I understand that some combinations may be used in some patients and not in others, based on known or hypothesized scientific information. I understand that a new drug or combination of drugs may be given to some patients and others will continue to receive a standard regimen to determine the effect on pregnancy rates (randomization).

I acknowledge that I have had an opportunity to ask questions about the use of fertility enhancing drugs in general and in my case specifically. I consent to the use of fertility enhancing drugs and understand that I may withdraw my consent at any time. I understand the risks, consequences, and benefits as explained to me and understand that I may request information on pregnancy rates and outcomes at any time.

Date	Signature of Patient	Patient Name – Print
Date	Signature of Witness	Witness Name – Print

NOTE: If you are unable to have this consent witnessed by a staff member at INVIA FERTILITY SPECIALISTS or FULLY UNDERSTAND THE CONSENT, please notify the INVIA FERTILITY SPECIALISTS medical staff. We will provide you with further information and a witness. If you wish to sign the consent outside of INVIA FERTILITY SPECIALISTS, please have the consent notarized.

State of _______, County of _______________ ss., I, the undersigned, a Notary Public in and for the said County in the State aforesaid; DO HEREBY CERTIFY that

____

(Female Patient/ Partner)
personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed, and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this _____ day of __________, 20____.
Commission expires on: _________, 20_____.

____

(Notary Public)

(Notary Seal)