

The Fertility Center of Colorado

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**CONSENT FOR USE OF GONADOTROPIN
RELEASING HORMONE ANALOG**

Patient Name _____ SS# _____

I, _____, the undersigned, request that Gonadotropin Releasing Hormone Analog be used in the treatment of infertility. I have been unable to achieve a pregnancy due to an infertility problem that has not been or cannot be corrected by any other currently available treatments.

I understand the following to be the rationale and technique for the administration of the Gonadotropin Releasing Hormone Analog (GnRH- analog):

1. The GnRH analog is intended to temporarily suppress the pituitary hormones that naturally control ovarian function and thereby improve the likelihood of successful superovulation.
2. While using a GnRH analog: other pharmaceutical agents such as Follicle Stimulating Hormone will be used to stimulate the maturation of eggs within the ovary.
3. I will participate in instructions for the preparation and administration techniques of medications prescribed for the treatment of infertility.

I understand the following to be risks and hazards related to the usage of GnRH analog. These include but are not limited to the following:

1. Hot flashes, nausea, vomiting, headache, rash or local reaction at the injection site may occur.
2. The most significant known risk to the use of the GnRH analog is that it could possibly induce formation of antibodies against the body's own native GnRH. This, in turn, could at a future time increase the likelihood of an ovulatory dysfunction (menstrual disturbance) and/or infertility.

I understand that treatment with a GnRH analog necessitates avoidance of pregnancy immediately prior to the initiation of the medication in order to eliminate any potential dangers to a developing embryo. I agree to use barrier contraception or maintain sexual abstinence beginning with menstruation in the cycle in which the GnRH analog is to be administered.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures and medications to be used, the hazards involved and I believe that I have sufficient information to give this informed consent.

Signed: _____ (Patient) Date _____

_____ (Witness) Date _____

The Fertility Center of Colorado:

Authorized Representative Date _____