



IVF Patient Manual



Life begins at the Genetics & IVF Institute

Welcome to the Genetics & IVF Institute,

Thank you for entrusting your care to the Genetics & IVF Institute (GIVF). We are totally committed to helping your family grow.

Since its founding in 1984, GIVF has been dedicated to providing expert medical care in a compassionate, patient friendly atmosphere. Known around the world as a leader in cutting edge infertility treatment, medical genetics and reproductive health, the Genetics & IVF Institute offers you an unparalleled array of medical experts and resources. Worldwide, GIVF is responsible for over 30,000 pregnancies.

It is our personal and professional mission to ensure that you receive the benefit of our extraordinary services in a warm, supportive environment that accommodates your individual needs.

We have created this book to help you navigate your IVF treatment easily. We hope you will find it helpful in anticipating your needs and answering questions. Our philosophy of care emphasizes patient education as well as interaction between patients and medical practitioners. Please feel free to bring us any questions, concerns or feedback you have at any time during your treatment. We are here to help you.

Sincerely,

The physicians, nurses and staff at GIVF

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Stephen R. Lincoln, MD, FACOG, is board certified in obstetrics and gynecology and subspecialty board certified in reproductive endocrinology and infertility. Dr. Lincoln is an expert in the diagnosis and treatment

of infertility including intrauterine insemination (IUI), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), non-surgical sperm aspiration, Donor Egg IVF, and advanced hysteroscopic and laparoscopic surgical procedures. In 2012, Dr. Lincoln led GIVF to create the Fertility Preservation Center for Cancer Patients and is the Medical Director.

In addition to his extensive experience in clinical practice, Dr. Lincoln is the author or co-author of over 30 book chapters and peer reviewed journal articles. He is a peer reviewer of articles for *Fertility and Sterility*, the monthly publication of the American Society for Reproductive Medicine.

Dr. Lincoln lectures at numerous national medical and scientific meetings and review courses. He has also been interviewed by national and local media on various aspects of infertility treatment.

Dr. Lincoln graduated from the University of Arkansas in 1982 with a degree in biology. He completed his medical school training at the University of Arkansas for Medical Sciences in 1986. He then completed a residency in obstetrics and gynecology at East Carolina University (1990) and a fellowship in reproductive endocrinology (1992) at the University of Louisville.

Dr. Lincoln has served as a faculty member at three university medical schools: the University of Louisville, the University of Mississippi, and the University of Tennessee at Memphis, where he was Director of Clinical Services of Reproductive Endocrinology and Infertility and rose to the rank of Associate Professor before joining the Genetics & IVF Institute in 1999. He is a member of several national professional organizations, including the American College of Obstetrics and Gynecology, the American Society for Reproductive Medicine, the Society of Reproductive Endocrinologists, and the American Medical Association.

Dr. Lincoln was named one of “America’s Top Obstetricians and Gynecologists” by the Consumer Research Council of America in 2007 and 2008. He was honored as one of the “Best Doctors in America” by Best Doctors in 2008 and was featured in Northern Virginia magazine’s January 2009 and February 2010 list of “Best Doctors.”



Laurence C. Udoff, MD, FACOG, is board certified obstetrics and gynecology and subspecialty board certified in reproductive endocrinology and infertility. Dr. Udoff joined GIVF in 2008 from the University of Maryland

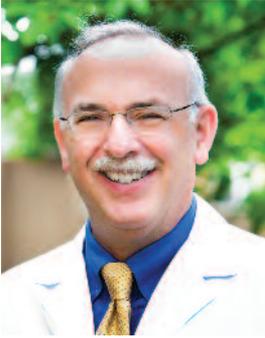
School of Medicine, where in addition to maintaining a clinical practice, he was Assistant Professor of Obstetrics, Gynecology and Reproductive Sciences. During his tenure at the University of Maryland, Dr. Udoff was Director of the Residency Program in Obstetrics and Gynecology and Director of the Preimplantation Genetic Diagnosis (PGD) program. He taught hundreds of students and residents. Prior to joining the Maryland faculty, Dr. Udoff practiced at the highly successful infertility program of The University of Utah School of Medicine, where he helped to establish the first PGD program in the Intermountain West.

Dr. Udoff's special interests include PGD and methods to improve IVF outcomes. Dr. Udoff graduated Phi Beta Kappa from the University of Delaware with a degree in Biology and received his medical degree from the University Of Maryland School of Medicine. He completed his residency training in Obstetrics and Gynecology at the University of Maryland. He completed one fellowship in Reproductive Endocrinology and Infertility at the University of Maryland and another at the University of Utah.

He is a member of the American College of Obstetrics and Gynecology, the Society for Gynecologic Investigation (full member), the American Society for Reproductive Medicine, Society for Reproductive Endocrinology and Infertility and the Preimplantation Genetic Diagnosis International Society.

Dr. Udoff has been the author or co-author of numerous book chapters, abstracts and peer-reviewed articles on topics in reproductive endocrinology and infertility. Dr. Udoff speaks frequently at meetings around the country and has appeared on local and national TV to discuss infertility. He was also featured in Northern Virginia magazine's February 2010 list of "Top-Rated Doctors." Dr. Udoff maintains his affiliation with the University of Maryland, where he serves as a Clinical Assistant Professor and shares his medical expertise with medical students and residents.

Dr. Udoff provides services in infertility, Donor Egg IVF, and Family Balancing. Dr. Udoff is also the lead physician on Donor Egg IVF and egg vitrification.



Harvey J. Stern, MD, PhD, FACMG, FAAP joined GIVF in 1995 and is the Director of Reproductive Genetics and the Fetal Diagnostic Center. Dr. Stern has extensive experience in the evaluation of congenital malformations in

the fetus and newborn and in diagnosis of genetic syndromes. He is the primary physician involved in providing amniocentesis, chorionic villus sampling, first trimester screening, and ultrasound for GIVF's prenatal genetics program. Dr. Stern is Medical Director of Fairfax Cryobank and of GIVF's Preimplantation Genetic Diagnosis (PGD) program. He also supervises genetic screening for GIVF's affiliates, Fairfax Cryobank and Fairfax EggBank. Dr. Stern also oversees GIVF's Endocrinology Laboratory.

Dr. Stern is board certified in pediatrics and medical genetics, with subspecialty board certification in clinical, biochemical and molecular genetics. He received his undergraduate degree in cell and molecular biology from Columbia College of Columbia University and completed a PhD in Human Genetics at Columbia University College of Physicians and Surgeons. He attended medical school at the Albert Einstein College of Medicine in New York. After a residency in pediatrics at Children's National Medical Center in Washington, DC, Dr. Stern completed a fellowship in medical genetics at UCLA.

Between 1987 and 1995, Dr. Stern was an attending physician in Medical Genetics and Laboratory Medicine at Children's National Medical Center, where he established the Biochemical Genetics Laboratory and the first molecular (PCR) based genetic diagnostic laboratory in a pediatric hospital. Currently, Dr. Stern is an Associate Professor of Human Genetics at Virginia Commonwealth University where he teaches a course in medical genetics.

He also teaches medical students in obstetrics and gynecology at Fairfax Hospital in Fairfax, Virginia. Dr. Stern is a member of many professional organizations, including the American Society for Reproductive Medicine, the American College of Medical Genetics, and the European Society of Human Reproduction and Embryology. He also has been elected to the International Fetoscopy Group, a highly selective and prestigious group of physicians known for their exceptional skills in prenatal diagnosis and genetic medicine.

Dr. Stern provides services in Reproductive Genetics including prenatal testing by chorionic villus sampling and amniocentesis, preimplantation genetic diagnosis (PGD), First-trimester genetic screening, pre or peri-conceptual genetic counseling and testing and Level II obstetrical ultrasound.

CONTACTING OUR PRACTICE

GIVF Main Phone:

Local: 703.698.7355

Toll Free: 800.552.4363

The phone is answered Monday through Friday from 8:00am to 4:00pm. On weekends and holidays, the main line plays a recorded message that will give you the prompts necessary to contact a clinician. If you are experiencing a medical emergency (excessive bleeding, fever or severe pain) page a physician, proceed directly to the nearest emergency room or dial 9-1-1.

Address:

3015 Williams Drive

Fairfax, VA 22031

Monitoring Hours:

Monday – Friday: 7:00am – 9:00am

Weekends/Holidays: 7:30am – 8:45am

Directions to the Genetics & IVF Institute

From Interstate 495 (Beltway) take Exit 50 to Route 50 West (Arlington Boulevard). Go through the underpass at Gallows Road, then turn right at the first stoplight onto Williams Drive. Park in the front or rear of the building and enter through the double glass doors.

From Fairfax/Burke/Manassas and Chantilly take Route 50 East. Turn left onto Williams Drive (2nd light after Prosperity Avenue).

The clinic is on the 3rd floor.

INITIAL CONSULT

Based on your medical history, age and how quickly you wish to pursue treatment, your doctor will order a number of diagnostic tests to evaluate both partners. The results of these tests will assist your doctor in formulating the type of procedure that will provide you with the most optimal chances of achieving a successful pregnancy.

In addition to the diagnostic tests, there are several steps we recommend to better prepare your body for a healthy pregnancy and delivery:

- Quit smoking
- Eat a balanced diet
- Take a prescription prenatal vitamin with at least 1mg Folic Acid
- Engage in regular exercise
- Investigate methods that will help decrease stress in daily life (ex. meditation, counseling, massage, acupuncture, support groups, hobbies, etc.)

Routine testing is done during this time to evaluate the most important aspects of fertility: eggs, sperm, structures such as fallopian tubes and the uterus, as well as hormone levels on one or both partners.

Frequently patients want to move forward as quickly as possible, but sometimes they prefer to delay until insurance changes, vacations are over, etc. If you let us know the speed at which you would like to proceed we can help you make arrangements accordingly.

HOW TO COUNT MENSTRUAL CYCLE DAYS

Note that many of the tests and appointments you have will revolve around certain days of your menstrual cycle. To determine what day of your cycle you are in, consider **day 1** to be when you have **full flow menstrual bleeding** (defined as having to wear a tampon or pad) **before 5:00pm**. If you spot for a day or two, we do not consider this to be the start of a cycle until the onset of full flow menses. If the flow begins after 5:00pm then the next day is considered “day one.” Contact your nurse on day 1 to plan testing on the appropriate days.

COMMON TESTING

EGG QUALITY TESTING (FSH & AMH)

Egg quality or ovarian reserve testing can be obtained with a blood draw ideally performed on day 3 of the menstrual cycle. Day 3 testing can actually be done anytime between days 2 – 5 but day 3 is optimal.

This simple blood test gives a prognosis of how efficiently the ovaries are working. A healthy ovary will only require a small level of follicle stimulating hormone (FSH) to produce an egg; whereas, if the ovary is not functioning as well, it will require substantially higher levels of FSH to produce an egg. High levels of FSH are typically a negative indicator of fertility; however, a normal FSH doesn't guarantee egg quality. In essence an elevated FSH is a poor indicator while a normal FSH is neutral.

Anti-Mullerian Hormone (AMH) is produced only in small ovarian follicles, so blood levels of this substance have been used to attempt to measure the size of the pool of growing follicles in women. Research shows that the size of this pool is heavily influenced by the size of the pool of remaining primordial follicles (microscopic follicles in “deep sleep”). Therefore, AMH blood levels are thought to reflect the size of the remaining egg supply - or “ovarian reserve”. With increasing age, the size

of a woman's pool of remaining microscopic follicles decreases as shown by lower AMH levels. Women with many small follicles, such as those with polycystic ovaries have high AMH hormone values and women that have few remaining follicles and those that are closer to menopause have low AMH levels.

Unfortunately levels of FSH and AMH cannot be improved to return to normal functioning with medication or exercise. Other treatment options could be discussed with your primary physician if appropriate.

If a more advanced test of ovarian reserve is recommended, this is done through a Clomid Challenge Test (CCT). A woman should begin with a low "resting" FSH level on day 3. Next, 100mg of Clomid is taken from days 5 – 9 of the menstrual cycle. After taking the last dose of Clomid, the FSH level should return to a normal level by the next day. If the ovaries are not functioning normally, the FSH level will still be elevated on day 10.

HYSTEROSONOGRAM (HYS)

It is important to confirm the uterine cavity is free from anything that would interfere with implantation or growth of an embryo (such as polyps, fibroids or adhesions). A transvaginal sonogram is done first to examine the ovaries and uterus. During the HYS, sterile saline is instilled into the uterus to evaluate the uterine cavity and anatomy. It should be performed between days 5 – 12 of your menstrual cycle and can be done at GIVF or a radiology facility.

HYSTEOSALPINGOGRAM (HSG)

This is a test to determine patency of the fallopian tubes and evaluate the cavity of the uterus. Dye is injected through the cervix, into the uterus and up the fallopian tubes as an x-ray is taken. The x-ray will show the structure to be open to the flow of dye, or blocked at some point, indicating an obstruction that could prevent sperm and egg from meeting. This test should be arranged between days 6 – 11 at a radiology facility and an antibiotic will be prescribed prophylactically.

LUTEAL PROGESTERONE

The Progesterone hormone is naturally produced in the body and is associated with the second half of the menstrual cycle, the “luteal phase”. This test is best used to determine ovulation. After ovulation occurs mid-way through the menstrual cycle, progesterone levels should rise to support a potential pregnancy or a supplement may be recommended. With IVF, a supplement is always used so this test is not necessary.

SEMEN ANALYSIS

The male partner should arrange this appointment at his earliest opportunity with the main scheduling department (703) 698-7355. A one to two day abstinence is typically recommended but in some cases a longer period may be advised. Sperm is evaluated on several parameters:

- Quantity (number of sperm in a single ejaculate)
- Morphology (percentage of normally shaped sperm)
- Motility (number of moving sperm)
- Progression (the quality of motion – traveling in a single direction and at a quick pace)

PRECYCLE TESTING

All partners are required to have precycle lab work that is current within one year of treatment. The female patient has a comprehensive list (infectious disease labs, hormone profile, prenatal panel including genetic screening if appropriate) since she will be the one carrying the pregnancy but if present, a male partner has an equally important list of infectious disease labs.

***All results of diagnostic testing will be discussed directly with you by your primary physician at the follow up appointment.

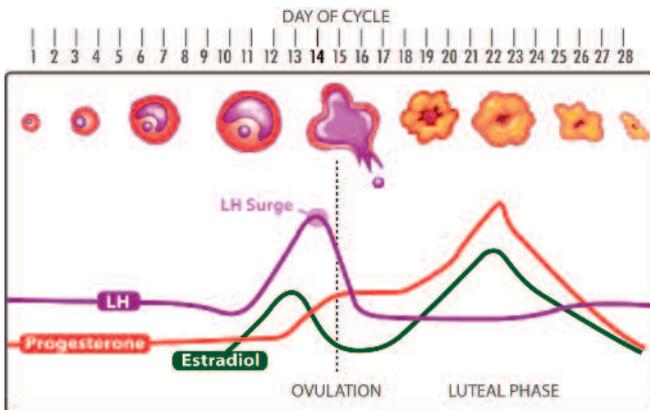
MENSTRUAL CYCLE REVIEW

FOLLICULAR PHASE (1st half of the menstrual cycle)

- This begins with the onset of the menstrual cycle
- Hormone levels (Estrogen, Progesterone and LH) are all at the lowest point of the cycle
- Uterine lining is sloughing off so it can start fresh
- Ovaries do not have any follicles measuring over 12mm
- As ovulation approaches, Estrogen level increases and uterine lining thickens
- One of the ovaries produces a dominant follicle (fluid filled sac that contains an egg). As it grows from <10mm to about 20mm, the egg inside is maturing to prepare for ovulation.

OVULATION

- The follicle reaches maturity, about 20mm in size
- The LH level rises dramatically and briefly
- The Estrogen level tapers off
- The egg inside the follicle matures and loosens from the follicle wall. The follicle itself bursts and the egg is expelled, floating down the fallopian tube where it will survive for approximately 24 hours.



LUTEAL PHASE (2nd half of the menstrual cycle)

- The egg leaves the ovary and travels down the fallopian tube
- The Estrogen level dips down and Progesterone level rises
- Progesterone is vital to the lining of the uterus called the “endometrium”. The lining has been growing thicker with the help of Estrogen; however, the addition of Progesterone is required to produce the right chemical combination for implantation and growth of an embryo.
- The endometrial lining must provide the right environment for an embryo to nestle in and begin to grow. Estrogen and Progesterone are the hormones that make this possible. In simple terms, Estrogen makes the endometrial lining “fluffy” while Progesterone makes it “sticky”.

PREGNANCY

- If an egg meets sperm on the way down the fallopian tube and is successfully fertilized, the newly created embryo will reach the endometrium a few days later and implant.
- The corpus luteum (what had been the follicle containing the egg that is now a cyst) continues the production of Progesterone to keep the endometrium thick and healthy.
- The newly implanted embryo will begin to produce the pregnancy hormone beta HCG (human chorionic gonadotropin).
- If no fertilization or implantation occurs, the body will stop the production of Progesterone. The rapid decrease in Progesterone levels is what causes another period to begin. The cycle starts all over again with the onset of a period.

SERVICES OFFERED AT GIVF

INTRAUTERINE INSEMINATION (IUI)

This is a process in which specially prepared (washed) sperm is placed directly into the uterus using a catheter to pass through the cervix. Unwashed sperm MAY NOT be placed in the uterus as severe reactions to proteins in the seminal fluid will occur. Patients monitor for ovulation using ovulation predictor kits (OPKs) at home or blood work and transvaginal ultrasounds at our facility. The physician will determine if medication is appropriate for the cycle. Most inseminations are scheduled for the day after a surge is detected or are timed 24 – 36 hours after a “trigger” shot is taken.

IN VITRO FERTILIZATION (IVF)

Simply put, an IVF cycle is an exaggeration of the first half of the regular menstrual cycle (follicular phase). Instead of one follicle producing one egg, the goal is to stimulate multiple follicles in both ovaries, thereby producing multiple eggs. Eggs are retrieved at the point of maturation and are combined with sperm in the IVF laboratory. With traditional IVF, the sperm is “poured” on the egg. This means the sperm is put into the petri dish that the eggs are in and fertilization takes place the same way it would in the fallopian tubes: millions of sperm fight to fertilize each egg. If fertilization takes place, the resulting embryos grow for 2 to 6 days in the IVF laboratory prior to being transferred into the woman’s uterus or frozen (depending on additional treatment options selected).

INTRACYTOPLASMIC SPERM INJECTION (ICSI)

ICSI increases the chance for fertilization even in the most difficult types of male infertility by injecting a single sperm directly into an egg. A glass pipette holds the egg in place and a single sperm is picked up in a micro-needle. The needle is gently pushed through the shell of the egg into the cytoplasm and the sperm is deposited deep inside the egg, then

the needle is withdrawn. Fertilization is not guaranteed with ICSI, but it does ensure sperm meets the egg. ICSI has been used for over 20 years and GIVF boasts the first ICSI pregnancy in the US. This is recommended when male factor infertility is identified from a Semen Analysis. ICSI is also used for fertilization of previously frozen eggs or with PGD.

ASSISTED HATCHING (AH)

This may be indicated in cases of advanced maternal age, previous failed IVF cycles, or the appearance of a thickened zona (outer shell). If recommended, an embryologist puts a very small nick in the zona thereby assisting the hatching. It is also performed to assist the embryo biopsy process when preimplantation genetic diagnosis (PGD) is used.

DONOR SPERM

In cases where there is no male partner or no viable sperm from a partner, anonymous donor sperm may be purchased from a sperm bank and shipped to GIVF. There are several sperm banks in the US but the most convenient one is our affiliate Fairfax Cryobank located in the same building www.fairfaxcryobank.com. Only one unit is needed per fertilization attempt. CMV status should be known (your physician will discuss this) so you can select an appropriate donor.

NON-SURGICAL SPERM ASPIRATION (NSA)

NSA is primarily used in cases of vasectomy, erectile dysfunction, azoospermia (no sperm) or severe oligospermia (few sperm), Congenital Absence of the Vas Deferens (CAVD) and para/quadruplegia. A tiny needle is used to extract a sample of testicular tissue to obtain sperm. It is performed in our clinic under the same sedation used with an egg retrieval and is painless and rapid. NSA must be done with ICSI because testicular sperm cannot penetrate the egg on its own and only a small number of sperm can be obtained (less than 100 versus millions in fresh ejaculate).

PERSONAL EGG BANKING (PEB) & FERTILITY PRESERVATION

Mature eggs can be frozen directly after retrieval for future use due to personal or medical reasons. They can remain frozen indefinitely. It is necessary to go through an IVF cycle to stimulate the ovaries and retrieve eggs.

DONOR EGG (Fresh or Frozen)

Donor Egg is an option available to those who are above the recommended age to try to conceive with their own eggs, who have abnormal diagnostic testing, or failed treatment with their own eggs that indicates the best chance for success is using eggs from an egg donor. There is a dedicated team on the nursing staff to walk patients through the process in detail and assist every step of the way. Eggs that are already frozen can be selected from our affiliate, Fairfax Egg Bank and used when the patient is ready to begin or a donor can be selected for a fresh match to synchronize the cycles together for treatment. Your physician will discuss in much further detail if this is recommended based on diagnostic testing or age.

PREIMPLANTATION GENETIC DIAGNOSIS (PGD)

Preimplantation genetic diagnosis (PGD) involves testing embryos created by IVF. The PGD results can help your physician determine which embryo(s) to transfer to increase the potential for a successful pregnancy and delivery.

There are different types of PGD available depending on what information is desired about an embryo. At GIVE, PGD by 24 chromosome microarray can identify if an embryo has extra or missing chromosomes (called chromosome aneuploidy). Since extra or missing chromosomes can cause failed implantation and/or early miscarriage, adding this test to an IVF cycle can reduce the miscarriage rate and/or increase the chance for a healthy pregnancy. PGD by 24 chromosome microarray can also determine the gender of an embryo for families at risk for a sex-linked disease or for family balancing.

PGD does not change or alter the genetic material of the embryo; it is a tool to help select which embryo(s) to transfer. It is important to remember that PGD can never be 100% accurate at any laboratory due to the limitations of working with embryos. It cannot test for all abnormalities and it cannot guarantee a healthy pregnancy; however, PGD can be a valuable testing tool in some IVF cycles.

If a family is at risk to have a pregnancy with a specific chromosome abnormality (such as a translocation) or a genetic disease (such as cystic fibrosis), a specialized type of PGD may be used to identify which embryo(s) should be transferred.

IVF is necessary for PGD to be performed. After the egg retrieval, eggs are fertilized with sperm using ICSI to create embryos. The embryos are observed in the laboratory until day 5 or 6 after fertilization when a small number of cells are removed from each appropriately developing embryo; this process is called biopsy and is required for PGD to be performed. The biopsied cells are tested and the PGD results are used to help determine which embryo(s) to transfer.

Although PGD may be considered in all IVF cycles, the people that may benefit the most from PGD are those who qualify for family balancing and/or that have an increased risk for chromosome abnormalities or a specific genetic disease. PGD may be indicated for: failed IVF cycles, maternal age, recurrent pregnancy loss, sperm abnormalities, or a personal/family history of chromosome abnormality of specific genetic disease. If you are interested in adding PGD to your IVF cycle, please speak with your physician and genetic counselor about whether PGD is right for you.

Helpful Links

IVF CLASS VIDEO:

<http://www.givf.com/aboutgivf/video/ivfclass.shtml>

INJECTION TRAINING VIDEOS:

<http://www.freedommedteach.com/eng/index.html>

PLANNING YOUR IVF CYCLE

Once you have completed all of your diagnostic testing, your physician will develop a treatment protocol specifically designed to meet your needs and your primary nurse will guide you through it. The following is the order of steps after you and your doctor agree on the treatment plan:

- Await your next menstrual period and contact your nurse for instructions (do not start any medications until advised)
- Your nurse will provide you with a calendar including tentative dates and review cycle details
- Arrange for financial clearance with your financial counselor as payment is required prior to the start of any treatment cycle and insurance authorization may take a couple weeks in some cases.
- Fertility medications (injectable) will be ordered from a specialty pharmacy. You will coordinate directly with them for delivery and payment.
- Attend brief injection training class to learn how to mix and administer injectable medications. You will be instructed to watch a video prior to injection training in the office.
- Schedule a precycle appointment with your nurse to review logistical details of the upcoming cycle including the medications so you are comfortable and know what to expect in the coming weeks. Most often this is done over the phone but can be in the office and you will need your medications in front of you.

IVF CYCLE TIMELINE

Step 1: Suppression

Typically one cycle of birth control pills is taken leading into the beginning of an IVF cycle. This can help decrease the chance of cysts being present that would interfere with response to the stimulation medication (gonadotropins). It may also help synchronize the growth of a better cohort of follicles when the ovaries are stimulated during the IVF cycle. Lastly, it can help to manipulate dates for the treatment cycle if a small window needs to be adjusted.

Not everyone is medically appropriate to use birth control pills and your physician will advise if an alternative is recommended.

Step 2: Stimulation

Once baseline is established at the start of the IVF treatment cycle, the next step is to begin stimulation medication (injectable fertility medications called Gonadotropins). In order for you to be ready to begin this phase, you must have low hormone levels, a thin uterine lining and no large cysts on the ovaries – this is typically what happens at the beginning of a menstrual cycle.

Fertility medications are typically taken for an average of 8 – 12 nights. You will need to come to the office for blood work and transvaginal sonograms about 5 – 6 times to monitor response to medication. Once deemed appropriate for the retrieval to be scheduled, a trigger injection is advised and the retrieval is scheduled two days later. Most cycles are completed within 10 to 14 days from the start of the gonadotropins.

Step 3: Egg Retrieval

You've reached the home stretch! On the day of egg retrieval, you will be at the office for about 2 ½ to 3 hours. Prior to the procedure, you will receive detailed instructions for medications and what to expect from the nurse and she will start your IV. You will consult with both the doctor

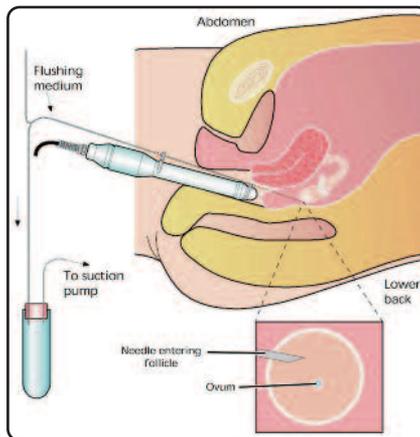
performing the procedure and an anesthesiologist. It is required to have NOTHING to eat or drink after midnight the night before or the procedure will be cancelled. This includes medications unless previously approved by medical staff. There must be a responsible adult to drive you home (taxi cabs are not permitted) as you cannot drive or work the day of retrieval.

The egg retrieval begins once you are sedated, sleeping comfortably. It only takes 20 – 30 minutes. The physician inserts an ultrasound probe to visualize the ovaries. There is a needle attached to the probe and it is inserted through the back of the vaginal wall so it is right next to the ovary. The doctor will puncture each follicle and withdraw the fluid from inside it. The lab will examine the fluid and ideally it will contain an egg.

After the procedure is finished, you will be assisted as you return to your recovery room and monitored. Once you are able to drink a little and urinate, you will be discharged to go home typically within an hour. The physician will update you on the procedure outcome before you leave the office. You will receive further updates over the next 5 to 6 days.

The sperm sample will be needed on this day at the same time (fresh, frozen or NSA) and appropriate instructions will be given to prepare in advance.

Egg Retrieval



Step 4: Embryo Transfer

On the day of embryo transfer, you will be at the office for about an hour. You will receive detailed instructions for preparation two days in advance. For this procedure a very close to full bladder is necessary so it will be REQUIRED to drink fluids before arriving. When you arrive, you will receive detailed instructions for medications and activity limitations.

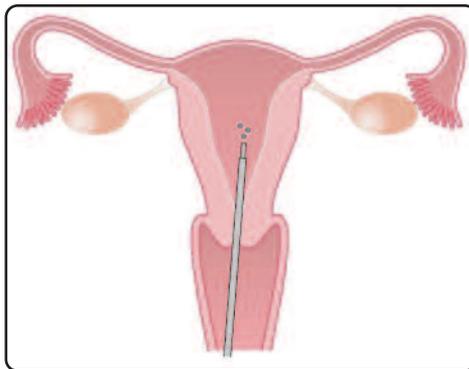
You will consult with the physician in detail about the embryo development and quality prior to making a final decision on which embryo(s) to transfer.

The procedure takes about 5 – 10 minutes on average. The procedure is performed under ultrasound guidance from the abdomen. A catheter is inserted through the cervix and the embryo(s) is placed into the top portion of the uterus (fundus).

You will remain on the exam table for about 10 minutes and then proceed home. If needed, you may drive yourself home from the procedure.

If eggs/embryos are being frozen, this step happens in a future cycle.

Embryo
transfer



Step 5: Pregnancy Test and Beyond

Two weeks after the egg retrieval there will be a blood test to check pregnancy outcome. The only way to know if an IVF cycle was successful is to do a blood pregnancy test for a serum HCG level. A urine test is not accurate this early.

If the blood pregnancy test is negative, all medications are discontinued. Progesterone may delay the start of a period. A menstrual cycle typically begins within 7 to 10 days after stopping the Progesterone (withdrawal bleeding happens from the drop in the Progesterone level just as with a normal menstrual cycle). Once the period begins, there is no lasting effect on the body from the IVF cycle. You will have a Cycle Review appointment over the phone or in the office with your primary physician to review the IVF cycle from start to completion and the recommendations from there.

If the blood pregnancy test is positive, it would be repeated in 3 to 7 days depending on the level to assess how the pregnancy is progressing. It is advised that you continue the Progesterone support after an IVF cycle generally until the 8th week of pregnancy until the placenta has taken over the production completely to support the pregnancy. Monitor your supply and order refills in advance so you don't run out.

A gestational ultrasound will be scheduled around 6 ½ to 7 weeks of pregnancy. The physician will confirm the pregnancy is in the uterus, the size is measuring appropriately and ideally detect a heartbeat. When those requirements are met, you will receive graduation papers to follow up with your ObGyn for the rest of the pregnancy.

WHAT TO EXPECT DURING MONITORING

The days and weeks leading up to the start of an IVF cycle are filled with many details that your primary nurse will help you manage so you're ready to go and as prepared and comfortable as possible. You will always receive detailed instructions and explanations of medication response so you stay informed throughout your cycle.

Never begin or stop a medication unless specifically advised by medication staff.

MONITORING

The first day of monitoring includes blood work and a transvaginal ultrasound to determine if it is appropriate to begin treatment. The following monitoring results determine how you are responding to the medication. Each appointment will determine when the next appointment will be as each cycle is unique and each woman will respond individually to the medications. Your nurse will give you a tentative calendar of dates to expect monitoring but it may vary slightly depending on the response. The average is 8 to 12 nights of medication and during that time you will need to be seen at the office for monitoring an average of 5 to 6 times.

Monitoring Hours:

Monday – Friday 7:00am – 9:00am

Weekends/Holidays 7:30am – 8:45am

Morning monitoring involves blood work most often combined with a transvaginal sonogram that usually takes about 20 to 30 minutes at the most. It must be completed first thing in the morning for results to be reviewed in the early afternoon to evaluate if any medication changes are necessary to optimize cycle outcome and avoid complications. Each day monitoring is performed, you will be contacted with an update on your response and specific instructions for the medication as well as when to return.

Monitoring typically begins with a simple blood draw to evaluate the hormone levels (Estrogen, Progesterone and LH but most important is the Estrogen level). There are no restrictions on eating/drinking prior to the blood work during a treatment cycle and in fact, the more hydrated you are, the easier the blood draw will be. We use the smallest needles (“butterfly”) to help decrease any discomfort and a very small amount is taken. At the beginning of an IVF cycle, it is normal for the Estrogen level to be low (<50). By the time you are ready for the retrieval, it is normal for the Estrogen level to be in the low thousands but medication dosage may be adjusted throughout the cycle to ensure a slow and steady rise along the way.

A trained sonographer performs the transvaginal sonogram and often a physician is in the room to explain what is visualized and answer questions. At the baseline appointment (initial monitoring appointment), we will look to make sure the uterine lining is thin and there are no large cysts that would interfere with the stimulation response. If those results are appropriate and the hormone levels are low, instructions will be given to begin the IVF stimulation medication.

The following ultrasounds will monitor follicular growth. A follicle is a fluid-filled sac in the ovary where the egg is contained. Not every follicle will have an egg inside, not every egg will be mature and not every mature egg will fertilize. The more you have to start with the better, but there is no specific number of follicles/eggs expected as it varies based on age and individual test results.

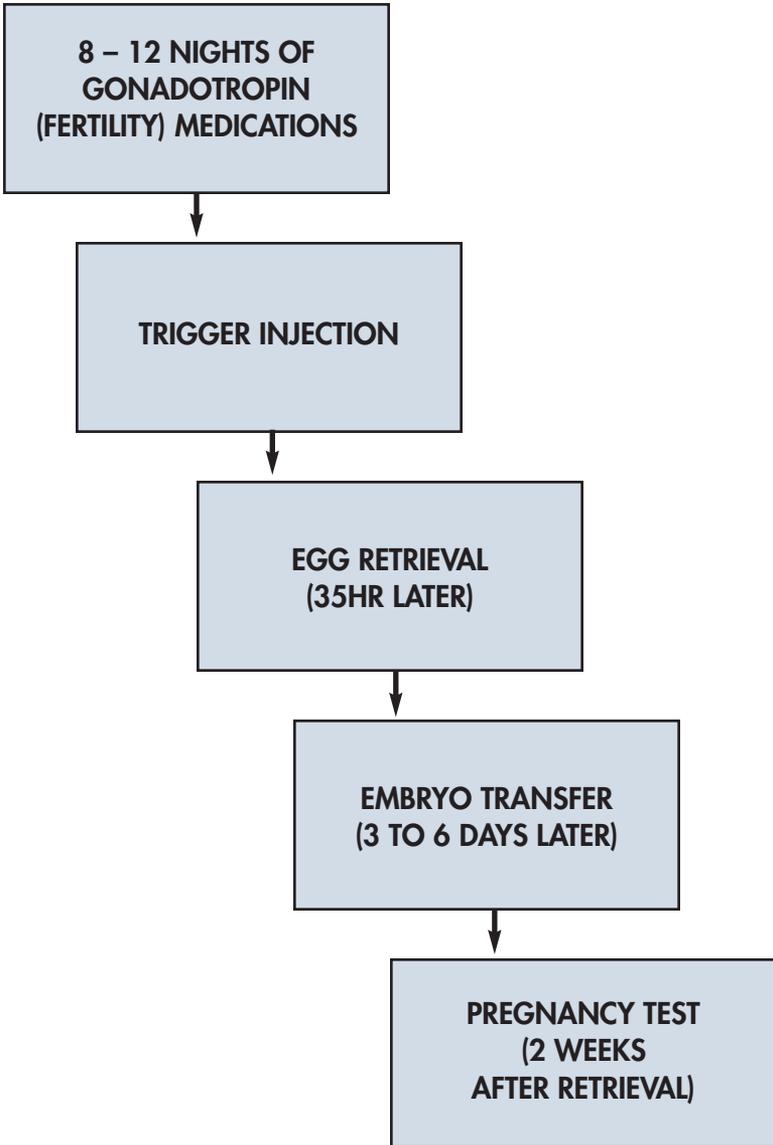
At the start of treatment, most follicles are less than 10mm. With the stimulation medication they grow larger each day. By the time you are ready for retrieval, the majority will be in the range of about 15 – 20mm.

Our physicians rotate days they see patients for consultation and days they perform procedures. When possible, your primary physician will perform the procedures but since it is not known well in advance what day your retrieval or transfer will occur, monitoring is a great opportunity to meet them and become more comfortable with all of them. If you do not see a physician during the ultrasound and would like to meet with them, they are available for a brief discussion.

Once deemed appropriate for the retrieval, you will be instructed to take a trigger injection. It will cause the egg to loosen from the follicle wall and float freely inside the follicular fluid. The physician aspirates the follicular fluid during the retrieval process for the lab to evaluate if an egg is present along with viability.



This is a photo of an ovary that has been stimulated with FSH medication for approximately 10 days. The dark areas are the follicles that contain an egg.



EMBRYO PROGRESSION

Day 0	Day of Egg Retrieval – total number of eggs known, combined with sperm in the afternoon.
Day 1	Total number of fertilized embryos known.
Day 2	No assessment
Day 3	Embryos are ideally expected to be between 6 – 8 cells. Transfer may be done this day in some circumstances.
Day 4	No assessment
Day 5	Ideally the embryos have reached the blastocyst stage. Usually one or two are transferred based on the individual patient situation. Remaining embryos may be cryopreserved or held to the following day. If PGD is performed, this is the day the biopsy is done on appropriate embryos.
Day 6	Embryos that did not reach the blastocyst stage will be re-assessed today for progression and possible cryopreservation. If PGD is being performed, they will be reviewed for progression to the appropriate stage for biopsy to take place.

DOs & DON'Ts WITH IVF

Try to avoid any unnecessary medications. The rule of thumb is that if your symptoms interfere with your major functioning (such as breathing, eating, sleeping, having bowel movements, and being free of pain or fever) then there is good reason to take medicine for them. Some medications that are generally considered safe with IVF and a potential pregnancy are Tylenol, Benadryl, Tums, plain Robitussin or plain Sudafed, baby aspirin, and Preparation-H. If you are significantly constipated (3 or more days without a bowel movement), you may use Colace or Pericolace or fiber based laxatives (Metamucil or Miralax). Most antibiotics are safe but inform your prescribing physician you are or may be pregnant.

DO:

- Avoid alcohol, smoking and drugs
- Always take a prescription prenatal vitamin
- Eat a well balanced diet and stay hydrated
- Exercise in moderation and get adequate rest
- Continue all current medications prescribed by other physicians but make sure to discuss with GIVF staff

DON'T:

- Start or stop any medication without being advised
- Take herbal supplements without discussing with GIVF staff
- Run out of medication- order refills in advance as needed!

Remember, you have a lot of people pulling for you including the physicians, nursing staff and counselors, so call us if you need to vent, cry, laugh or ask questions!

CRYOPRESERVATION & FROZEN EMBRYO TRANSFER CYCLE

In some circumstances, egg or embryo freezing is planned ahead of time or remaining embryos not transferred in a fresh cycle may be frozen for future use if desired. The embryologist will recommend which embryos are appropriate to freeze based on their progression. Then the physician will discuss this directly with you so you can make an informed decision but the choice to cryopreserve embryos is entirely yours. It is important to review your decision with your financial counselor so you know your responsibility when you are ready to begin a frozen transfer cycle.

Depending on the stage at which embryos are frozen, approximately 90% will survive the thawing process. Survival of unfertilized eggs is more variable, and this would be discussed directly with each patient by their primary physician as it can vary depending on several factors. The process for a frozen embryo transfer cycle is the same whether using eggs or embryos (eggs just require the extra step of fertilization prior to the transfer).

It is a much simpler and less physically demanding process to go through than the stimulated IVF cycle and retrieval. Typically one cycle of oral contraceptives is used leading into the month for the frozen embryo transfer so it is a two month process. Your nurse will coordinate the calendar based on your menstrual cycle and provide tentative dates for you to plan for monitoring and the transfer.

First, you will be assessed with a baseline monitoring visit of blood work and ultrasound. This is to confirm that everything is quiet before you begin the medications to prepare the uterus for the embryo(s) to be transferred. The hormone levels should be low and the uterine lining thin as well as no large active cysts on the ovaries. As long as that is seen, then you're ready to begin the next medication.

The primary medication used in a frozen cycle is Estrace (Estradiol) tablets. These are typically taken orally but can also be used vaginally depending on the medication response and cycle history. The Estrace tablets are used to stimulate the uterine lining to become nice and thick and fluffy to support implantation of an embryo. It is taken for an average of 12 – 15 nights during which there are 2 to 3 monitoring visits to assess response to medication. Once an adequate uterine lining is seen (minimum 6.5 – 7mm), it is time to prepare for the transfer.

At this point, the Estrace will continue to support the endometrial lining. Then we will add Progesterone to make the lining sticky to aid in embryo implantation and support a potential pregnancy. An antibiotic is started prophylactically to prevent infection around the time of transfer. The transfer is then scheduled .

A pregnancy test would be performed 2 weeks after the Progesterone is started. If positive, the Estrace and Progesterone both continue until the 10th week of pregnancy. At that point they are both discontinued as the placenta has fully taken over the production to support the pregnancy.

It is extremely important that you DO NOT run out of the medications or the pregnancy could be impacted. There are plenty of refills at your pharmacy so make sure to contact them in advance.

OVARIAN HYPERSTIMULATION SYNDROME

Ovarian Hyperstimulation Syndrome (OHSS) is a complication that can occur with IVF but is typically seen in less than 1% to 2% of patients. It is important not to confuse OHSS with a normal stimulation response. By definition, IVF hyperstimulates the ovaries by causing more follicles to grow and mature than they would during a regular menstrual cycle.

IVF treatment will likely cause some degree of bloating, a feeling of fullness and possibly lead to gaining a couple of pounds due to fluid retention. Feeling a little tired may also be normal. You likely will not feel like wearing your tightest pair of pants for a few days around the retrieval.

Monitoring during the IVF cycle helps to assess response to the medication and if the physician is concerned the patient is at higher risk the dosage is adjusted to try and prevent this from happening. There is also further medication that can be used in appropriate circumstances and this would be discussed directly with the physician so the patient is aware of the risk and options.

Symptoms of hyperstimulation usually present within the first few days AFTER the egg retrieval is done or later (may be days or weeks after the last gonadotropin injection). The symptoms of OHSS may include nausea, vomiting, diarrhea, extreme bloating, rapid weight gain, difficulty breathing (short of breath), and being uncomfortable to the point where walking, sleeping and activities of daily life are impacted.

Feeling sick to the point of not being able to go about your normal daily activities is not normal and should be brought to the attention of the medical staff right away. If you're not sure how you feel, don't hesitate to call and discuss with the office so they can help determine if you should come in for evaluation.

If it is appropriate for you to come in for evaluation, you would have a blood test, transvaginal ultrasound and vital sign monitoring. If the ultrasound shows accumulation of fluid in the cul-de-sac (the space behind the uterus), a procedure called a culdocentesis will be advised. It is very similar to an egg retrieval but instead of retrieving eggs, the fluid that has accumulated is aspirated. The procedure lasts about 20 – 30 minutes and the same conscious sedation is used that was given during the egg retrieval so there can be no food or drink prior to arriving to the office. All patients must have a ride home as they cannot drive themselves or return to work that day. Relief is usually immediate but in some cases the fluid can return and more than one procedure may be needed.

Close monitoring while on the stimulation medication helps to prevent this and more conservative medication protocols to help ward off OHSS are used in those who are identified based on age and diagnostic testing to be at higher risk.

MEDICATIONS USED WITH IVF TREATMENT

Your nurse will order your IVF medications for you as soon as your financial counselor gives clearance. IVF medications are no small part of the cost of doing an IVF cycle. A typical pharmacy bill can average between \$3,000 - \$6,000 or more for each cycle. We will work to help determine if there is coverage for your medications and order accordingly. If you have insurance coverage, the nurse will order the medications at the pharmacy approved by your insurance company. If you are self-pay for the medications, the nursing staff will order them conservatively at a pharmacy that is cost effective and certain pharmaceutical companies offer coupons/rebates to save additional cost.

Your physician will devise a medication protocol based on your age and diagnostic testing to elicit the most optimal response to the medications. Most medications are injectable and you will be thoroughly prepared on how to administer them to yourself or a partner if applicable at injection training class. Once the medications are received, your nurse will review each one to make sure everything is clear prior to beginning any medication. You will always receive detailed instructions when any medication is started, adjusted or stopped based on monitoring results.

The nurse will order the amount of medication that should last for the whole cycle, but if the dosage is increased or you take more than the average number of nights of medication then you may need to get a refill. It is your responsibility to monitor your medication supply so you don't run out. Your nurse will estimate as best possible but inform the staff if you're running low so we can advise how much to refill.

IVF MEDICATION TIMELINE

No medications should be started, changed or discontinued without instructions from the medical staff.

1) Prescription prenatal vitamins

Any brand is appropriate as long as it contains at least 27mg of Iron and 1mg Folic Acid. Over the counter vitamins frequently don't have enough. This is taken to guard against certain types of birth defects called neural tube defects, including spina bifida and anencephaly. They should be taken daily while trying to conceive, throughout pregnancy and during breastfeeding.

2) Birth control pills

Many patients will use oral contraceptive pills (OCP) daily prior to the start of an IVF cycle to prepare the ovaries and uterine lining to be at an appropriate baseline point prior to starting the IVF medications. This may help decrease the chance of cysts being present that would interfere with response to the stimulation medication. It also works to synchronize the growth of a better cohort of follicles when the ovaries are stimulated during the IVF cycle. Lastly, it can help to coordinate dates and overcome logistical obstacles such as vacation plans or holidays. Typically patients take OCPs for three weeks and often a period begins within a few days after finishing the birth control pill prior to beginning the stimulation medication.

Not everyone is medically appropriate to use birth control pills and your physician will advise if an alternative is recommended.

3) Suppression medication

This medication will prevent ovulation while on the stimulation medication so that you do not ovulate on your own prior to the retrieval. Consistency is imperative and you will receive specific instructions on when to administer this medication. All types of suppression medication are injected subcutaneously, and you will be on one type determined by your physician based on your diagnostic testing.

THE THREE TYPES INCLUDE:

Lupron – taken once daily in the morning (started while on OCP)

Microdose Lupron – take every twelve hours (twice per day)

Ganirelix (Antagon) or Cetrotide – taken once per evening

4) Gonadotropin (stimulation) medication

These drugs are designed to stimulate multiple follicles to develop in each ovary. They are taken for an average of 8 to 12 nights but that can vary. All are subcutaneous and should be taken in the evening between 6 to 9pm. You will be on one or more of Gonal F, Follistim, Bravelle and Menopur.

5) Trigger medication

When the growing follicles reach the appropriate size to plan the retrieval (majority are between 15 – 20mm), you will be instructed to take your trigger medication. It will cause the eggs to loosen from the follicular wall to prepare for the retrieval where they will be aspirated in the follicular fluid. It is a timed injection and the retrieval is scheduled roughly 35 hours later. There are two different trigger medications: HCG (human chorionic gonadotropin) or Lupron trigger and the physician will advise which one is the best medical recommendation.

6) Antibiotic

This is taken prophylactically to ward off infection after the egg retrieval. Most commonly Doxycycline is used but others may be recommended based on medical history/allergies. It is started the evening of the egg retrieval until the evening of the transfer or all tablets are gone.

7) Progesterone

This is taken as a supplement to your own body's production of Progesterone. It helps nourish the lining of the uterus, making implantation and growth of an embryo more likely. It will start at the time of retrieval and continue until the 8th week of pregnancy (6 weeks total). You will be on one of the following:

Progesterone in oil – IM injection taken once daily

Crinone gel 8% – vaginal applicator used once daily

Endometrin – inserted vaginally three times daily

8) Baby Aspirin

In some cases one 81mg tablet is recommended to help thin the blood, which may increase blood flow to the uterus to create a better uterine lining for implantation to occur.

IVF CLASS VIDEO:

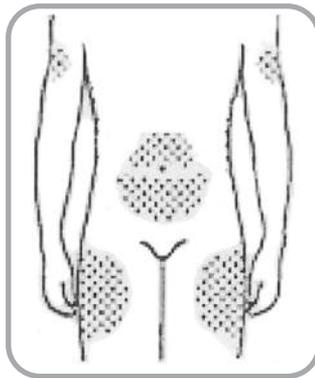
<http://www.givf.com/aboutgivf/video/ivfclass.shtml>

INJECTION TRAINING VIDEOS:

<http://www.freedommedteach.com/eng/index.html>

SUBCUTANEOUS (SUBQ) INJECTION

Most medications with the IVF cycle are administered by subcutaneous injection in either the back of the upper arm, in a 2 in radius below the belly button or the top of the thigh. Prior to handling medicine or giving an injection, you should always wash your hands thoroughly with soap for 20 – 30 seconds. Once the medication is ready for the injection, wipe the injection site with an alcohol swab and let it dry completely. After the injection, you may gently apply pressure with a gauze pad for a few seconds. Don't worry if you see a drop of liquid or blood at the injection site initially. Also, small bruising is not uncommon at the injection site and does not indicate a problem. You will be thoroughly prepared for all medications you are instructed to take.



*Subcutaneous
injection site
diagram*

INTRAMUSCULAR (IM) INJECTION

Typically the only injection that is not subQ is the Progesterone used after the egg retrieval. Usually it is given in the behind (buttock) as that is the muscle that best tolerates the injection. The injection can be done by yourself but it is easier if there is another person to give it if possible. You will receive detailed written instructions from a nurse on the day of retrieval and directed to watch a video prior to beginning.

FAQS

1) Is it safe to have intercourse during IVF?

Each patient is unique but in most cases if feeling okay, there is no reason to avoid intercourse except if the partner is providing a fresh sample during the two day abstinence leading up to the retrieval day. Some patients will need to use protection if having intercourse due to treatment type. Make sure to discuss with your nurse or physician if you are unsure.

2) Will I be guaranteed to have my physician for all of my procedures?

We do our best to try and have your procedure with your primary physician but due to coverage 7 days a week and days they rotate for procedures and consults, you may be seeing another physician for the procedure. No matter who it is, they will sit down with you beforehand to review what to expect and answer questions. Hopefully you will have met during morning monitoring evaluations as well.

3) What are common side effects during IVF?

Headaches may sometimes occur in the early days of an IVF cycle due to lower Estrogen levels but usually they dissipate quickly after the stimulation medicine is started. IVF treatment will likely cause some degree of bloating, a feeling of fullness and possibly lead to gaining a couple of pounds due to fluid retention (though it should dissipate soon after the cycle is completed). Feeling a little tired may also be normal. Most women do not report mood changes.

4) How much can I exercise during my IVF cycle?

It is recommended to avoid excessive, strenuous exercise once you begin the stimulation medication. High impact aerobics or targeting the mid-section directly (crunches, etc.) should be avoided. It is important whenever exercising to stay well hydrated. We recommend activities that are more gentle or gliding movements such as walking, using the elliptical, swimming, and yoga.

5) I had my embryo transfer a couple days ago, is it normal to have cramping and discharge?

It is not uncommon to have some minor cramping and/or spotting after the procedure the same day and after. It would be concerning if there is heavy bright red bleeding or severe pain after the transfer.

6) Is it okay if I take my medication outside the advised times I was instructed?

There is a window of time that is advised with different medications. Stimulation medications should be administered between 6 to 9pm, but it does not have to be the same time each day. The trigger injection to plan for the egg retrieval **MUST** be taken when instructed or the egg retrieval may be compromised. Estrace tablets for a frozen embryo transfer are advised to be taken every twelve hours to keep blood levels of Estrogen at a therapeutic level but there is a two hours window that it can vary (ex. If 8am and 8pm are the chosen times, it can be taken between 7am to 9am). Progesterone that is taken every twelve hours (Crinone gel) may vary within the same two hour window. Progesterone that is taken once per day (Intramuscular) is most effective when taken with the same two hour window (ex. If choosing 8am then it is okay between 7 to 9am).

7) Now that I'm pregnant, can you tell me if it's twins from the HCG level?

There is no way to tell by the numbers alone if the pregnancy is one or two babies. The goal is one healthy singleton as it's an easier pregnancy for both mom and baby. The only way to know for certain is at the gestational ultrasound performed around 6 ½ to 7 weeks along.

8) If the first cycle is not successful and I want to do another right away, how quickly can I begin again?

The fastest time the next cycle could begin is every other month. Whether the next step is a frozen embryo transfer or another IVF cycle, there is one month of “rest” that needs to happen in between. Most often to plan the next calendar, the patient would restart birth control pills with a period to lead into the next treatment the following month. Medically there is no benefit to wait longer or to begin right away. It is completely dependent on whether the patient needs time for emotional, physical or financial reasons.

9) Is there anything else I should or shouldn't be doing?

Unfortunately, there is no magic formula for success. It is fine to go about your activities of daily life including having sex, going to work, doing chores, running errands, traveling, holding or lifting a small child.

IMPORTANT INFORMATION FOR OUT OF TOWN PATIENTS

We have many patients that plan and originate their IVF cycle from other states or countries. You will need to arrange the diagnostic testing with either your regular ObGyn or PCP and a radiology facility though a local fertility clinic may also be used. The Semen Analysis should be done at a fertility clinic for the most accurate results. Your regular ObGyn will need to follow you during your pregnancy once it is established as well as a local physician in the case of any complications (preferably a fertility clinic). If you are initiating the cycle at home before traveling to GIVF, you will need to have monitoring at a fertility clinic that can provide same day results for blood work and transvaginal ultrasounds. The results will need to be sent to GIVF for interpretation and instructions before 2p EST on weekdays and before 12pm EST on weekends. It is recommended if you begin the monitoring and stimulation injections locally to arrive to GIVF after the five to six nights of medication so that we can monitor you ourselves for the rest of the cycle. This ensures medication instructions and retrieval timing are based on the most accurate results using our own equipment and technicians. To find a local fertility clinic, visit the America Society for Reproductive Medicine at www.reproductivefacts.org, click on Resources at the top and select Find a Healthcare Professional.

Timing you can expect to be at GIVF will vary based on whether you plan on completing early monitoring at home. On average patients can expect to be here between 1 to 2 weeks and your nurse will advise a tentative timeframe when the calendar is planned.

PLANNING YOUR STAY

We want your stay in the Washington, D.C. area to be as pleasant as possible and we will do everything we can to assist you and to minimize your time away from home. Although you will need to come to GIVF for morning monitoring and your procedure, there should be time in between to explore and relax.

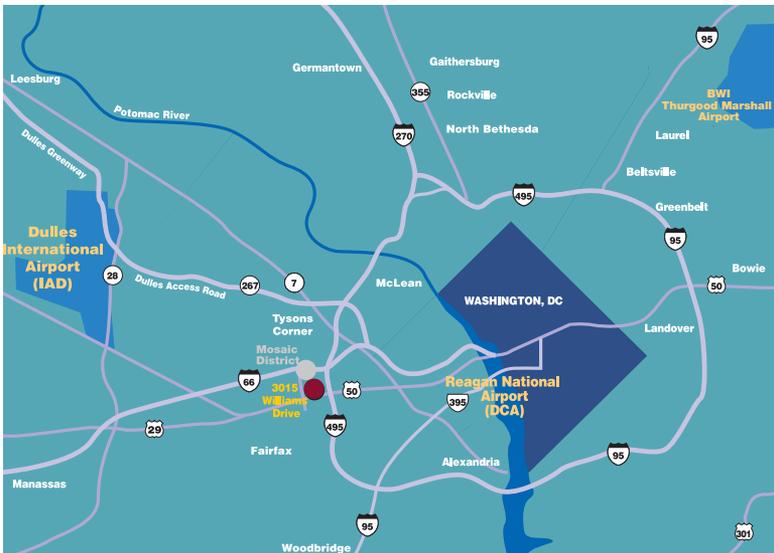
Please visit our website www.givf.com for a complete listing of hotels, restaurants and areas of interest in the Washington Metropolitan region.

AIRPORTS

IAD – Dulles International Airport (30 minutes from GIVF)

DCA – Reagan National Airport (30 minutes from GIVF)

BWI – Baltimore Washington International Airport
(60+ minutes from GIVF)



CAR RENTALS

Budget Rent A Car	800.218.7992
Thrifty Rent A Car	800.367.2277
Avis	800.331.1212
Hertz	800.654.3131
National Car Rental	800.227.7368

LIMOUSINES

Affordable Airport Shuttle	703.578.6666
Airport Connection Sedan Services	703.533.5500
Corporate Car Service, Inc.	703.536.2277
Dominion Limousine	703.359.0800
Red Top Executive Sedan Services	703.522.3300
Reston Limousine Service	703.478.0500

TAXI CABS

Red Top Cabs	703.522.3333
Diamond Cab	703.549.6200
Yellow Cab	703.549.2500
Diamond Transportation	703.548.6500

HOTELS

Hyatt House, Falls Church, VA	571.327.2277
Fairview Park Marriott, Falls Church, VA	703.849.9400
Courtyard by Marriott, Vienna, VA	703.573.9555
Residence Inn, Falls Church, VA	703.573.5300
Homewood Suites, Falls Church, VA	703.560.6644
Hampton Inn, Fairfax, VA	703.385.2600
Ritz Carlton, McLean, VA	703.560.4300

A MESSAGE ABOUT INFERTILITY

If you are one of the many diagnosed with infertility, you are not alone. More than 6 million Americans will confront infertility. The good news is that with the proper medical treatment, more than 70% of people diagnosed with infertility can conceive. Often unexpected, dealing with infertility can be one of the most trying experiences in your life as you find yourself going down new and never imagined paths. While medical treatment options continue to improve, the choices and decisions faced can be difficult to make at times. Infertility can impact you, your social life, family life, finances, relationships and work. It can be stressful and often changes your image of how and when you will have a child. Knowing you are not alone is important in reducing stress and anxiety as you navigate through the medical testing, decisions and procedures.

While stress does not directly cause infertility, it impacts your overall health. Prolonged stress can lead to anxiety, depression or even a sense of isolation and desperation. This type of stress has a negative impact on being able to keep medical processes in perspective. Having information to understand your options and treatment plan is critical and will add to your sense of control. If you are concerned about the impact infertility is having on you or your partner, please contact your nurse to get recommendations for a licensed professional so you can benefit from valuable resources.

<http://www.givf.com/patientsupport/index.shtml>

RESOLVE: The National Infertility Association

www.resolve.org/support/helpline

HELPFUL COPING STRATEGIES

Understand your treatment

Knowledge often reduces the fear and anxiety that contribute to stress. The goal of this manual is to provide information so you are more knowledgeable about what is going to take place over the next couple of months. If you have any questions, please don't hesitate to ask your primary nurse or physician to explain further. We know you are receiving a lot of information and at times it may be confusing, we are here to help.

Participate in and track your treatment

Write down any questions, concerns, or observations and take notes when possible during meetings with your medical team. Keep track of all information related to your care. Document your results and monitoring along with procedure information or request copies of your results to keep in your personal files. Some women keep a journal to record their experience.

Take care of yourself

Don't neglect your overall health. Be kind to yourself, eat right, exercise, get enough sleep and it's okay to indulge occasionally.

Consider counseling or a support group

The empathy and objectivity of a good counselor can help you understand and deal with the emotions associated with infertility. Strength and perspective can also be gained by sharing your experiences and feelings with others in the same situation. It helps to know you are not alone.



www.givf.com • 800.552.4363
3015 Williams Drive, Fairfax, Virginia 22031

