

**CONSENT TO BE A GESTATIONAL SURROGATE**

I, \_\_\_\_\_, of \_\_\_\_\_ County, City of \_\_\_\_\_ in the state of \_\_\_\_\_ am over the age of twenty-one years. I voluntarily offer my service as a gestational surrogate for \_\_\_\_\_ and \_\_\_\_\_.

**1. Party/Parties participating in the process of assisted reproductive technology with gestational surrogacy:**

- a. Oocyte or eggs will be extracted from \_\_\_\_\_
- b. Sperm will be obtained from \_\_\_\_\_
- c. Eggs from 1.a and sperm from 1.b will be fertilized in the laboratory.
- d. The resulting normally fertilized eggs (embryo or embryos) will be placed into the uterus of \_\_\_\_\_.
- e. Intended parents

i. Couples

\_\_\_\_\_ and \_\_\_\_\_ are the intended parents of any and all child(ren) resulting from this procedure.

ii. Individual

\_\_\_\_\_ is the sole intended parent of any and all child(ren) resulting from this procedure.

**2. Nature and purpose of gestational surrogacy**

Gestational surrogacy involves a woman carrying a pregnancy for another individual or couple. Usually the individual or couple (the intended parent(s)) requesting gestational surrogacy treatment cannot carry a pregnancy for medical or non-medical reasons. The intended parent(s) go through an in-vitro fertilization (IVF) cycle with or without donor eggs and/or sperm. The gestational surrogate bears no genetic relationship to the resulting child or children. After normal fertilization is achieved, the fertilized eggs are cultured in the laboratory for an appropriate period of time before they are placed inside a gestational surrogate’s uterus (womb) with the intent of making the gestational surrogate pregnant.

**3. Specific steps for the gestational surrogate**

Before the gestational surrogacy treatment can begin, consultation with an attorney familiar with assisted reproductive technology (ART) law is mandatory. Legal contracts between the intended parents and the gestational surrogate must be completed before any treatment.

Suitability of all parties involved for this procedure will be determined by standard infertility evaluation, screening tests, psychological counseling and other medical procedures where required by federal, state or local law or deemed medically necessary by the treating physician.

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

Gestational surrogacy can involve a fresh IVF cycle where the eggs are retrieved, fertilized, cultured and transferred in the same cycle. In the alternative, the embryos can be frozen and embryo transfer to a gestational surrogate takes place in a frozen embryo transfer cycle.

**A. Preparation of the uterine lining**

Regardless of whether a fresh or frozen embryo transfer is involved, the uterine lining of the surrogate must be prepared so that the embryo(s) can be transferred to an optimal uterine environment. The gestational surrogate named in Section 1.d will undergo serial ultrasound examinations and blood testing for reproductive hormones to assist in preparation of the uterine lining. She will also self administer hormones to prepare the uterine lining in preparation for embryo transfer.

There are a number of ways the uterine lining can be prepared. Generally suppression of spontaneous cycles is used, followed by priming of the lining with estrogen and progesterone. Suppression of spontaneous cycle is necessary when a pre-birth order is sought. Since the surrogate did not ovulate, the pregnancy can only be the result of the embryo transfer. This issue is important in states that allow pre-birth orders, permitting the intended parents to have them named as the parents in the birth certificate.

a. Medications to suppress spontaneous cycle

i.. Oral contraceptive pills

Oral contraceptive pills may be taken for 2 to 4 weeks before estrogen and progesterone are given. Side effects include bleeding, headache, breast tenderness, nausea, swelling and the risk of blood clots or stroke.

ii. GnRH-agonists (leuprolide acetate) (Lupron®)

This medication is taken by injection. There are two forms of the medication: A short acting medication requiring daily injections and a long-acting preparation lasting for 1-3 months. The primary role of this medication is to temporarily suppress menstrual cycle and ovarian function. Though leuprolide acetate is an FDA (U.S. Food and Drug Administration) approved medication, it has not been approved for use in ART, although it has routinely been used in this way for more than 20 years. Potential side effects usually experienced with long-term use include but are not limited to hot flashes, vaginal dryness, bone loss, nausea, vomiting, skin reactions at the injection site, fluid retention, muscle aches, headaches, and depression. No long term or serious side effects are known. Since GnRH-agonist are oftentimes administered after ovulation, it is possible that they will be taken early in pregnancy. The safest course of action is to use a barrier method of contraception (condoms) the month you will be starting the GnRH-agonist. GnRH-agonist has not been associated with any fetal malformations; however, GnRH-agonist must be discontinued as soon as pregnancy is confirmed.

iii. Estradiol

Initials\_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

Blood test and ultrasound will be used to decide if adequate suppression of spontaneous cycle is achieved. Then estradiol, the most potent estrogen produced in the body by the ovaries, will be taken by mouth, skin patch or injection. Side effects include nausea, irritation at the application site if given by the trans-dermal route, and the risk of blood clots or stroke. The dosage of estradiol will be adjusted according to blood level and ultrasound measurement of the uterine lining. Estradiol is continued for two to three months after a pregnancy has been confirmed.

iv. Progesterone

Progesterone is normally produced by the ovaries after ovulation. Along with estradiol, it plays a vital role in supporting a pregnancy. Progesterone is usually started either on the day of oocyte retrieval in a fresh embryo transfer cycle or three to five days before a frozen embryo transfer. It is given by injection or by the vaginal route. (Endometrin®, Crinone®, Prometrium®, or pharmacist-compounded suppositories) Progesterone is often continued for two to three months after a pregnancy has been confirmed. Progesterone has not been associated with an increase in fetal abnormalities. Side effects of progesterone include depression, sleepiness, and allergic reaction. If progesterone is given by intra-muscular injection, there is the additional risk of infection or pain at the injection site.

v. Other medications

Antibiotics may be given for a short time before embryo transfer to reduce the risk of infection. Antibiotic use may be associated with causing a yeast infection, nausea, vomiting, diarrhea, rashes, sensitivity to the sun, and allergic reactions. Occasionally, anti-anxiety medications or muscle relaxants may be recommended prior to the embryo transfer. The most common side effect is drowsiness. Where indicated, other medications such as steroids, heparin, low molecular weight heparin or aspirin may also be included in the treatment protocol.

**B. Embryo transfer**

After a few days of development when the requisite cell divisions have occurred, a pre-determined number of embryos will be selected for transfer into the uterus of the gestational surrogate named in Section 1.d. with a thin tube (catheter). Ultrasound guidance may be used to help guide the catheter and confirm placement of the embryos at a proper location in the uterine cavity. Although the possibility of a complication from the embryo transfer is very rare, risks include infection and loss of, or damage to the embryos.

a. Number of embryos to transfer

The number of embryos transferred influences the pregnancy rate and the multiple pregnancy rate. The age of the woman from whom the eggs are obtained and the appearance of the developing embryo have the greatest influence on pregnancy outcome and the chance for multiple pregnancy. While it is possible, it is unusual to develop more fetuses than the number of embryos transferred. The number of embryos to be transferred must be determined and agreed upon by the physician, the intended parents (named in Section 1.e) and the gestational surrogate (named in Section 1.d) **before** embryo transfer.

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

b. Limits on the number of embryos to transfer

In an effort to curtail the problem of multiple pregnancies, some countries have enacted law regulating the number of embryos to transfer. At the moment of this writing, no such law has been enacted in the U.S. at the federal, state or local level. Because multiple pregnancies (see Section 4.B.f) can be devastating to the health of both mother and children, national guidelines published by the Practice Committee of the Society in Assisted Reproductive Technologies (SART) of the American Society for Reproductive Medicine (ASRM) in 2006 recommend limits on the number of embryos to transfer (see Tables below). All clinics, including the Family Fertility Center, which are members of SART are to follow these guidelines or risk losing their membership with SART. These limits differ depending on the developmental stage of the embryos and the quality of the embryos and take into account the patient’s personal history.

**Recommended limits on number of 2-3 day old embryos to transfer**

| <b>Embryos</b> | <b>age &lt;35</b> | <b>age 35-37</b> | <b>age 38-40</b> | <b>age &gt;40</b> |
|----------------|-------------------|------------------|------------------|-------------------|
| favorable      | 1 or 2            | 2                | 3                | 5                 |
| unfavorable    | 2                 | 3                | 4                | 5                 |

**Recommended limits on number of 5-6 day old embryos to transfer**

| <b>Embryos</b> | <b>age &lt;35</b> | <b>age 35-37</b> | <b>age 38-40</b> | <b>age &gt;40</b> |
|----------------|-------------------|------------------|------------------|-------------------|
| favorable      | 1                 | 2                | 2                | 3                 |
| unfavorable    | 2                 | 2                | 3                | 3                 |

Favorable means previous successful IVF outcome, first IVF cycle, good embryo quality, or excess embryos available for freezing.

c. Single embryo transfer

While there is no absolute guarantee to avoid multiple pregnancy, single embryo transfer is the only option to minimize the possibility of multiple pregnancy and its inherent risks to the health of mother and children and is the recommended choice for favorable prognosis as noted in Section 3.B.b.

\_\_\_\_\_ and \_\_\_\_\_ (name(s) of intended parent(s))

and

\_\_\_\_\_ (name of the gestational surrogate)

agree to have (write the number of embryo(s) to be transferred, then place initials after the number)

\_\_\_\_\_ embryo(s) transferred on 2<sup>nd</sup> to 3<sup>rd</sup> day after fertilization, or

\_\_\_\_\_ embryo(s) transferred on 5<sup>th</sup> to 6<sup>th</sup> day after fertilization.

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

- C. Determine if pregnancy has occurred

Following transfer of the fertilized eggs, blood samples from the gestational surrogate will be obtained to determine if pregnancy has occurred and if it is progressing normally.

**4. Risks of Gestational Surrogacy**

Data specific to pregnancies resulting from gestational surrogacy is non-existent. The following are data from pregnancies with IVF as a result of fresh embryos transfer to the same woman who underwent ovarian stimulation and oocyte retrieval.

- A. Risks to the surrogate undergoing embryo transfer

- a. Pregnancy resulting from IVF

Generally pregnancy resulting from IVF are associated with increased risks of certain conditions (see Table below from the Executive Summary of a National Institute of Child Health and Human Development Workshop held in September 2005, as reported in the journal *Obstetrics & Gynecology*, vol. 109, no. 4, pages 967-77, 2007). Some of these risks stem from the higher average age of women pregnant by IVF and the fact that the underlying cause of infertility may be the cause of the increased risk of pregnancy complications. There may be additional risks related to the IVF procedure per se, but it is difficult to assign the relative contributions.

**Potential Risks in Singleton IVF-conceived Pregnancies**

| <b>Maternal Risks</b> | <b>Absolute Risk (%) in IVF-conceived Pregnancies</b> | <b>Relative Risk (vs. non IVF-conceived Pregnancies)</b> |
|-----------------------|---|--|
| Pre-eclampsia         | 10.3%   | 1.6 (1.2--2.0)   |
| Placenta previa       | 2.4%  | 2.9 (1.5--5.4)   |
| Placental abruption   | 2.2%  | 2.4 (1.1--5.2)   |
| Gestational diabetes  | 6.8%  | 2.0 (1.4--3.0)   |
| Cesarean delivery *   | 26.7%   | 2.1 (1.7--2.6)   |

In this table, the Absolute risk is the percent of IVF Pregnancies in which the risk occurred. The Relative Risk is the risk in IVF versus the risk in non-IVF pregnancies; for example, a relative risk of 2.0 indicates that twice as many IVF pregnancies experience this risk as compared to non-IVF pregnancies. The numbers in parentheses (called the "Confidence Interval") indicate the range in which the actual Relative Risk lies. \*Please note that most experts believe the rate of Cesarean delivery to be well above the 26.7% rate quoted here.

Currently more than 30% of IVF pregnancies are twins or higher-order multiple gestations (triplets or greater), and about half of all IVF babies are a result of multiple gestations. Identical twinning occurs in 1.5% to 4.5% of IVF pregnancies. IVF twins deliver on average three weeks earlier and weigh 1,000 gm less than IVF singletons. Of note, IVF twins do as well as spontaneously conceived twins. Triplet (and greater) pregnancies deliver before 32 weeks (7 months) in almost half of cases.

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

## b. Ectopic pregnancy

While embryos are transferred directly into the uterus with IVF, ectopic (tubal, cervical and abdominal) pregnancies as well as abnormal intra-uterine pregnancies have occurred either alone or concurrently with a normal intra-uterine pregnancy. These abnormal pregnancies oftentimes require medical treatments with methotrexate (a weak chemotherapy drug) or surgery to treat the abnormal pregnancy. Side effects of methotrexate include nausea or vomiting, diarrhea, cramping, mouth ulcers, headache, skin rash, sensitivity to the sun and temporary abnormalities in liver function tests. Risks of surgery include the risks of anesthesia, scar tissue formation inside the uterus, infection, bleeding and injury to any internal organs.

## B. Risks to the child/children conceived with IVF

## a. Overall risks.

Since the first birth of an IVF baby in 1978, more than 3 million children have been born worldwide following IVF treatments. Numerous studies have been conducted to assess the overall health of IVF children and the majority of studies on the safety of IVF have been reassuring. As more time has passed and the dataset has enlarged, some studies have raised doubts about the equivalence of risks for IVF babies as compared to naturally conceived babies.

A major problem in interpreting the data arises from the fact that comparing a group of infertile couples to a group of normally fertile couples is not the proper comparison to make if one wants to assess the risk that IVF technology engenders. Infertile couples, by definition, do not have normal reproductive function and might be expected to have babies with more abnormalities than a group of normally fertile couples. This said, even if the studies suggesting an increased risk to babies born after IVF prove to be true, the absolute risk of any abnormal outcome appears to be small.

Singletons conceived with IVF tend to be born slightly earlier than naturally conceived babies (39.1 weeks as compared to 39.5 weeks). IVF twins are not born earlier or later than naturally conceived twins. The risk of a singleton IVF conceived baby being born with a birth weight under 5 pounds nine ounces (2500 grams) is 12.5% vs. 7% in naturally conceived singletons.

## b. Birth defects

The risk of birth defects in the normal population is 2-3 %. In IVF babies the birth defect rate may be 2.6-3.9%. The difference is seen predominately in singleton males. Studies to date have not been large enough to prove a link between IVF treatment and specific types of birth defects.

## c. Imprinting disorders

These are rare disorders having to do with whether a maternal or paternal gene is inappropriately expressed. In two studies approximately 4% of children with the imprinting disorder called Beckwith-Weidemann Syndrome were born after IVF, which is more than expected. A large

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

Danish study however found no increased risk of imprinting disorders in children conceived with the assistance of IVF. Since the incidence of this syndrome in the general population is 1/15,000, even if there is a 2 to 5-fold increase to 2-5/15,000, this absolute risk is very low.

d. Childhood cancers

Most studies have not reported an increased risk with the exception of retinoblastoma: In one study in the Netherlands, five cases were reported after IVF treatment which is 5 to 7 times more than expected.

e. Infant development

In general, studies of long-term developmental outcomes have been reassuring so far; most children are doing well. However, these studies are difficult to do and suffer from limitations. A more recent study with better methodology reports an increased risk of cerebral palsy (3.7 fold) and developmental delay (4 fold), but most of this stemmed from the prematurity and low birth weight that was a consequence of multiple pregnancy.

**Potential Risks in Singleton IVF Pregnancies**

| <b>Perinatal Risks</b>                   | <b>Absolute Risk (%) in IVF Pregnancies</b> | <b>Relative Risk (vs. non-IVF Pregnancies)</b> |
|--|---|--|
| Preterm birth                            | 11.5%                                       | 2.0 (1.7--2.2)                                 |
| Low birth weight (< 2500 g)              | 9.5%  | 1.8 (1.4--2.2)                                 |
| Very low birth weight (< 1500 g)         | 2.5%  | 2.7 (2.3--3.1)                                 |
| Small for gestational age                | 14.6%                                       | 1.6 (1.3--2.0)                                 |
| NICU (intensive care) admission          | 17.8%                                       | 1.6 (1.3--2.0)                                 |
| Stillbirth                               | 1.2%  | 2.6 (1.8--3.6)                                 |
| Neonatal mortality                       | 0.6%  | 2.0 (1.2--3.4)                                 |
| Cerebral palsy                           | 0.4%  | 2.8 (1.3--5.8)                                 |
| Genetic risks                            |   |  |
| -imprinting disorder                     | 0.03%                                       | 17.8 (1.8--432.9)                              |
| -major birth defect                      | 4.3%  | 1.5 (1.3--1.8)                                 |
| -chromosomal abnormalities (after ICSI): |   |  |
| -of a sex chromosome                     | 0.6%  | 3.0  |
| -of another chromosome                   | 0.4%  | 5.7  |

In this table, the Absolute risk is the percent of IVF Pregnancies in which the risk occurred. The Relative Risk is the risk in IVF versus the risk in non-IVF pregnancies; for example, a relative risk of 2.0 indicates that twice as many IVF pregnancies experience this risk as compared to non-IVF pregnancies. The numbers in parentheses (called the "Confidence Interval") indicate the range in which the actual Relative Risk lies.

f. Risks of a multiple pregnancy

i. Preterm labor and delivery

Initials \_\_\_\_\_

## CONSENT TO BE A GESTATIONAL SURROGATE

The most important maternal complications associated with multiple gestation are preterm labor and delivery, pre-eclampsia, and gestational diabetes (see Section 4.A.a Risks of pregnancy resulting from IVF). Others include gall bladder problems, skin problems, excess weight gain, anemia, excessive nausea and vomiting, and exacerbation of pregnancy-associated gastrointestinal symptoms including reflux and constipation. Chronic back pain, intermittent heartburn, postpartum laxity of the abdominal wall, and umbilical hernias also can occur. Triplets and above increase the risk to the mother of more significant complications including post-partum hemorrhage and transfusion.

### ii. Prematurity

Prematurity accounts for most of the excess perinatal morbidity and mortality associated with multiple gestations. Moreover, IVF pregnancies are associated with an increased risk of prematurity, independent of maternal age and fetal numbers. Fetal growth problems and discordant growth among the fetuses also result in perinatal morbidity and mortality. Multifetal pregnancy reduction (where one or more fetuses are selectively terminated) reduces, but does not eliminate, the risk of these complications.

### iii. Fetal death

Fetal death rates for singleton, twin, and triplet pregnancies are 4.3 per 1,000, 15.5 per 1,000, and 21 per 1,000, respectively. The death of one or more fetuses in a multiple gestation (vanishing twin) is more common in the first trimester and may be observed in up to 25% of pregnancies after IVF. Loss of a fetus in the first trimester is unlikely to adversely affect the surviving fetus or mother. No excess perinatal or maternal morbidity has been described resulting from a "vanishing" embryo.

Demise of a single fetus in a twin pregnancy after the first trimester is more common when they share a placenta, ranging in incidence from 0.5% to 6.8%, and may cause harm to the remaining fetus.

### iv. Additional risks to multiple fetuses

Multiple fetuses (including twins) that share the same placenta have additional risks. Twin-twin transfusion syndrome in which there is an imbalance of circulation between the fetuses may occur in up to 20% of twins sharing a placenta. Excess or insufficient amniotic fluid may result from twin-to-twin transfusion syndrome. Twins sharing the same placenta have a higher frequency of birth defects compared to pregnancies having two placentas. Twins sharing the same placenta appear to occur more frequently after blastocyst transfer.

Placenta previa (placenta extends over the cervical opening) and vasa previa (where one or more of the blood vessels extends over the cervical opening) are more common complications in multiple gestations. Abruption placenta (premature separation of the placenta) also is more common and postpartum hemorrhage may complicate 12% of multifetal deliveries. Consequences of multiple gestations include the major sequelae of prematurity (cerebral palsy, retinopathy of prematurity, and chronic lung disease) as well as those of fetal growth restriction (polycythemia,

Initials \_\_\_\_\_



## **CONSENT TO BE A GESTATIONAL SURROGATE**

hypoglycemia, necrotizing enterocolitis). It is unclear to what extent multiple gestations themselves affect neuro-behavioral development in the absence of these complications. Rearing of twins and high-order multiples may generate physical, emotional, and financial stresses, and the incidence of maternal depression and anxiety is increased in women raising multiples. At mid-childhood, prematurely born offspring from multiple gestations have lower IQ scores, and multiple birth children have an increase in behavioral problems compared with singletons. It is not clear to what extent these risks are affected by IVF per se.

### **v. Option of selective reduction**

Pregnancies that have more than 2 fetuses are considered an adverse outcome of infertility treatment. The greater the number of fetuses within the uterus, the greater is the risk for adverse perinatal and maternal outcomes. Patients with more than twins are faced with the options of continuing the pregnancy with all risks previously described, terminating the entire pregnancy, or reducing the number of fetuses in an effort to decrease the risk of maternal and perinatal morbidity and mortality. Multifetal pregnancy reduction (MFPR) decreases risks associated with preterm delivery, but often creates profound ethical dilemmas. Pregnancy loss is the main risk of MFPR. However, current data suggest that such complications have decreased as experience with the procedure has grown. The risk of loss of the entire pregnancy after MFPR is approximately 1%.

In general, the risk of loss after MFPR increases if the number of fetuses at the beginning of the procedure is more than three. While there is little difference between the loss rates observed when the final number of viable fetuses is two or one, the loss rate is higher in pregnancies reduced to triplets. Pregnancies that are reduced to twins appear to do as well as spontaneously conceived twin gestations, although an increased risk of having a small for gestational age fetus is increased when the starting number is over four. The benefit of MFPR can be documented in triplet and higher-order gestations because reduction prolongs the length of gestation of the surviving fetuses. (This has been demonstrated for triplets; triplets have a 30-35% risk of birth under 32 weeks compared to twins which is 7 to 10%)

## **5. Ethical and religious considerations in gestational surrogacy**

Gestational surrogacy can raise concerns and questions of an ethical or religious nature for some people. The technique of in-vitro fertilization (IVF) involves the creation of human embryos outside the body and can involve the production of excess embryos and/or 'high-order' multiple pregnancy (triplets or more). Carrying a pregnancy for another person may be viewed as a noble and charitable act by some. This same act may be criticized as unnatural or against the will of God by others. You are encouraged to consult with trusted members of your religious or ethics community for guidance on your decision to be a gestational surrogate.

## **6. Legal considerations and legal counsel**

In cases when embryos are frozen for later use or when a third party is involved in the process of IVF, the law regarding parent-child status, rights of sperm or egg donors, gestational surrogate and child(ren) resulting from this treatment is, or may be, unsettled in the state in which either

Initials \_\_\_\_\_

## CONSENT TO BE A GESTATIONAL SURROGATE

partner or spouse, or any donor currently or in the future lives, or in the state of Pennsylvania where Family Fertility Center is located.

Family Fertility Center has not given you legal advice, nor should you rely on the Family Fertility Center to give you any legal advice. You are strongly advised to consult a lawyer who is experienced in the area of assisted reproduction technology law if you have any questions or concerns about any aspect of this consent and agreement.

### 7. Psychosocial effects of gestational surrogacy

Gestational surrogacy is not for everyone. We strongly urge you to have professional counseling **before** you decide to become a gestational surrogate.

Symptoms of pregnancy can be minor and tolerable by some women but debilitating to others. Pregnancy itself causes a multitude of physiological changes. Fortunately most of these changes are adaptable by the body. Occasionally serious life-threatening changes as described in Section 4.A.a can occur.

While it is normal to experience emotional ups and downs while pregnant as a surrogate, it is important to recognize when these feelings are of a severe nature. If you experience any of the following symptoms over a prolonged period of time, you may benefit from working with a mental health professional:

- Feeling of regret
- Strained interpersonal relationships (with partner, family, friends and/or colleagues)
- Loss of interest in usual activities
- High levels of anxiety.
- Diminished ability to accomplish tasks
- Difficulty with concentration
- Change in your sleep patterns (difficulty falling asleep or staying asleep, early morning awakening, sleeping more than usual for you)

When the gestational surrogacy is complete at delivery, the gestational surrogate has to no further contact with the child or children resulting from this process. This may bring joy, satisfaction and fulfillment to some surrogates that their good deeds are done. Conversely the separation may trigger or aggravate post partum depression in others.

Our health care team can assist you to identify a local qualified mental health professional who is familiar with the emotional experience of being a gestational surrogacy.

### 8. Reporting IVF outcome

The 1992 Fertility Clinic Success Rate and Certification Act requires the Centers for Disease Control and Prevention (CDC) to collect cycle-specific data as well as pregnancy outcome on all assisted reproductive technology cycles performed in the United States each year and requires them to report success rates using these data. Consequently, data from your gestational surrogacy

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

procedure will be provided to the CDC, and to the Society of Assisted Reproductive Technologies (SART) of the American Society of Reproductive Medicine (ASRM). The CDC may request additional information from the Family Fertility Center or contact you directly for additional follow-up. Additionally, your information may be used and disclosed in accordance with HIPAA guidelines in order to perform research or quality control. All information used for research will be de-identified prior to publication. De-identification is a process intended to prevent the data associated with your treatment from being used to identify you as individuals.

**9. References**General IVF overviews available on the internet

<http://www.sart.org/>

<http://www.cdc.gov/art/>

Number of Embryos to Transfer

Single Embryo Transfer

[http://sart.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Committee\\_Opinions/eSET-nonprintable.pdf](http://sart.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/eSET-nonprintable.pdf)

Guidelines on number of embryos transferred. The Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Assisted Reproductive Technology. Fertil Steril 2006; 86 (suppl 4): S51-S52.

Culturing Embryos to the Blastocyst Stage

Blastocyst culture and transfer in clinical-assisted reproduction. The Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Assisted Reproductive Technology. Fertil Steril 2006; 86 (suppl 4): S89-S92.

Risks of pregnancy

Infertility, assisted reproductive technology, and adverse pregnancy outcomes. Executive Summary of a National Institute of Child Health and Human Development Workshop. Reddy UM, Wapner RJ, Rebar RW, Tasca RJ. Obstet Gynecol 2007; 109(4):967-77.

Risks to offspring

Infertility, assisted reproductive technology, and adverse pregnancy outcomes. Executive Summary of a National Institute of Child Health and Human Development Workshop. Reddy UM, Wapner RJ, Rebar RW, Tasca RJ. Obstet Gynecol 2007; 109(4):967-77.

Multiple pregnancy associated with infertility therapy. The Practice Committees of the American Society for Reproductive Medicine Fertil Steril 2006; 86 (suppl 4): S106-S110.

Imprinting diseases and IVF: A Danish National IVF cohort study. Lidegaard O, Pinborg A and Anderson AN. Human Reproduction 2005; 20(4):950-954.

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

**10. Acknowledgement**

I accept the gestational surrogacy procedure as my own voluntary act and acknowledge that the child or children produced are the legitimate children of \_\_\_\_\_ and \_\_\_\_\_.

I accept and agree that I will have neither the rights nor the duties of a parent to any offspring born as a result of my gestational surrogacy procedure. Furthermore, I waive any right to make legal claims against the intended parent(s), doctor(s) involved in this gestational surrogacy procedure, and the Family Fertility Center with regard to parental rights including disclosure of information, visiting rights, shared custody, inheritance and maternity.

I understand that in the state of Pennsylvania, there is no statute that specifically addresses the legal rights and responsibilities of a gestational surrogate, the intended parent(s) and any offspring born as a result of these procedures. I acknowledge that I have been advised to consult an attorney for further clarification of my legal interests.

I, jointly and severally, hereby agree to indemnify and hold harmless Dr. H. Christina Lee, the Family Fertility Center, its staff, and their successor, assigns, heirs and executors and administrators from and against any and all liability, in connection with any claim brought by me, or any other person or entity in connection with the gestational surrogacy procedure.

If I become pregnant, the medical cost for the treatment of any complication related to my pregnancy may or may not be covered by insurance. Furthermore, financial compensation for any injury and any other incidental or consequential damages directly or indirectly arising from the gestational surrogacy is not available. I agree that that compensation will not be demanded of the physician or staff at the Family Fertility Center. Furthermore, I agree to refrain from bringing legal action of any kind, and refrain from aiding or abetting anyone else in bring legal action for or on account of any matter or things which might arise out of my service as a gestational surrogate.

I have had the opportunity to read and ask questions about the contents of this document and all the components of gestational surrogacy treatment. I understand the information provided and my questions have been answered to my satisfaction. I execute this consent form freely and voluntarily. I have not relied on any inducements, promises, or representations made by Dr. H. Christina Lee, the Family Fertility Center or its staff.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Initials \_\_\_\_\_

**CONSENT TO BE A GESTATIONAL SURROGATE**

The foregoing was read, discussed, and signed in my presence, and in my opinion the person signing did so freely, and with full knowledge and understanding.

\_\_\_\_\_  
Print Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

I have explained to the above individual the nature and purpose of the procedure; the potential benefits, and possible risks associated with participation in this procedure. I have answered all questions that have been raised by the above individual.

\_\_\_\_\_  
H. Christina Lee, M.D., J.D., H.C.L.D.

\_\_\_\_\_  
Date

Initials \_\_\_\_\_