



CONNECTICUT
FERTILITY
ASSOCIATES



EGG DONATION

& SURROGACY

The Gift of Life

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CONNECTICUT FERTILITY ASSOCIATES

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Introduction to EGG DONATION & SURROGACY *The Gift of Life*

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Introduction

EGG DONATION *The Gift of Life*

Egg donation is commonly used in situations in which a woman does not produce enough eggs, or if her eggs are unable to produce a healthy pregnancy. For example, women over 40 often require an egg donor because of normal aging processes. Younger women with premature menopause or genetic diseases may also need a donor. More and more men are also opting to begin their families using egg donation.

Using in vitro fertilization (IVF) techniques, the donated eggs are retrieved and fertilized in our IVF laboratory. The fertilized eggs develop into embryos which are then transferred into the recipient woman for implantation, and a healthy pregnancy is established.

Egg donation brings together medical, psychological, legal and sometimes ethical concerns. It also involves a series of synchronized processes or steps. This booklet is designed to give you information about each of the aspects of the egg donation process; and to review many of the questions that our patients have asked us in the past.

Conceiving with Egg Donation: Is it right for you?

Egg donation has become an exciting option for women and men who otherwise would not be able to conceive. Because the eggs used in egg donation are obtained from young, healthy donors, pregnancy rates are extremely high, exceeding those of all other fertility therapies. As a rule, the age of the egg donor is the most important factor that determines whether a healthy pregnancy is established. As long as the recipient's uterus is capable of carrying a pregnancy (which is typically not age-dependent), she can almost always have children using this revolutionary therapy.

The indications for egg donation have grown considerably since its inception. Many women can successfully have children using donor eggs, including: (1) women who are unable to bear children because they no longer produce eggs, either because of natural menopause or because of premature ovarian failure; (2) women who produce eggs monthly, but whose eggs are not robust enough to be fertilized and lead to a pregnancy; (3) women who are carriers of genetic diseases and choose not to become pregnant with their own eggs (since they would be at risk for having a child affected with that disease); (4) women who have undergone multiple cycles of fertility therapies using their own eggs without success; and (5) patients who have undergone medical or surgical treatments (chemotherapy, radiation, or surgical removal of their ovaries) that have rendered them unable to conceive using their own eggs.

More and more men are also now opting to begin their families using egg donation and gestational surrogacy. Over the years CFA has worked with hundreds of single men and same-sex couples to enable them to achieve biological parenthood. In fact, many gay male couples often share the eggs from their donor, enabling eggs to be fertilized by each man. They then transfer the best embryo from each partner into their carrier, who then has an excellent chance of carrying twins – one from each dad! Other couples prefer to only transfer embryos from one father, and often freeze the remaining from the other father for future siblings. Regardless of your personal preference regarding matters such as these, Dr. Doyle will listen carefully and guide you to determine which approach best matches with your family-building goals and desires.



GETTING STARTED

Your first visit is crucial to many facets of your care. After you have decided that egg donation and/or surrogacy are right for you, you will meet or speak with Dr. Doyle. During that meeting you will share your goals and expectations, and he will outline the medical treatment plan which is most right for you. You will also meet our strong support team, who will then step in and assist you in choosing your donor, and scheduling all necessary clinical and administrative appointments, bloodwork, and tests. These appointments are critical to laying the groundwork for your care, and will enable us to establish clear and achievable timelines and expectations for you

*Medical Director,
Michael B. Doyle, M.D.*



the first step CHOOSING YOUR EGG DONOR

Once you decide that egg donation is right for you, you usually begin the process by choosing your donor. CFA offers an outstanding list of donors from which to choose, and there is **NO WAITING LIST**. To ensure that the pregnancy which results will be as healthy and low-risk as possible, all of our egg donors have been prescreened for literally hundreds of characteristics including medical status, physical characteristics, mental health, heritage and family history, and overall fertility. A donor profile exists for each donor, which contains over 30 pages of her health and personal information, as well as personal essays, SAT scores, description of hobbies, and in most cases photos. The results of her medical screening, including infectious diseases and genetic testing are all available for your viewing.

The donor profiles can be accessed via the internet using a private personalized password which one of our donor coordinators will provide to you. They can also be mailed or e-mailed to you. You can begin the process anytime by going directly to CFA's egg donor bank at www.EggDonorMatch.com; or to our general website at www.CTfertility.com.

Connecticut Fertility Associates offers four options for donor matching:

Option A · Complete Egg Donor Cycle.

This choice ensures that you receive up to 25 eggs from your chosen donor. This maximizes your likelihood of success and increases your chance of achieving subsequent pregnancies using frozen embryos which are most likely to result from this option.

Option B · Shared Egg Donor Cycle

This option involved sharing eggs from your with other parents. This shared cycle usually results in your receiving up to ten of the eggs which she produces. This option reduces donor-related costs but is less likely to result in "extra" embryos for future use.

Option C · Frozen Eggs

Sometimes we freeze or cryopreserve eggs which have been previously harvested at Connecticut Fertility Associates, and then stored them for future use. These eggs are available for use any time and do not require the synchronization that is always necessary when a donor and a carrier re going through the process in parallel. Since implantation rates are lower with embryos that come from frozen eggs rather than fresh eggs, we recommend transferring a larger number of embryos.

Option D · Embryo Adoption

Occasionally when some people are finished with their family building and do not wish to discard their "extra" embryos, they choose to donate their extra embryos to CFA to give to others.

We will discuss with you in detail the pros and cons of each of these options once you begin your journey with us, and help you to decide which option best meets your needs and goals.

PREPARING FOR EGG DONATION

Screening & Requirements for the Egg Donor

To be eligible to be an egg donor, the donor must first complete the following screening tests.

Initial Interview

During this visit, the egg donor meets with members of CFA's medical and nursing personnel, who will discuss all aspects of her testing and treatment cycle, review possible risks, and develop and explain her specific testing and treatment plan.

General & Gynecological Exam

The egg donor undergoes tests relevant to the maintenance of a safe and healthy pregnancy including a complete physical examination, pelvic exam, Pap smear and cervical cultures.

Blood Work

The egg donor must also undergo extensive blood testing which is strictly required by the FDA to screen for important transmissible medical conditions such as HIV, hepatitis, and syphilis. This bloodwork is required once you are matched, and must also be repeated within one month of the donation.

Genetic Counseling

Every donor is required to undergo genetic counseling and screening by CFA's Genetic Counselor, and to demonstrate normal testing of her karyotype (chromosomes) along with screening for common diseases such as cystic fibrosis, Fragile X and hemoglobinopathies (anemias). In addition, she is also screened for those genetic diseases which are more common to her specific heritage.

Psychological Interview

During this session, our psychologist will assess the donor's psychological suitability for the process. The psychologist also assures adequate informed consent, and determines that the donor fully understands and accepts the future rights of both the donor and the recipient. In addition, standardized psychological testing will be performed to evaluate the donor's personality traits and overall emotional stability.

Instruction

The egg donor is given personalized instruction regarding the administration, dosages, timing and safety of each of the medications she may be using including, injectable Lupron®, gonadotropins and HCG. Arrangements for the ordering and delivery of these (and any other) medications will also be made.

Costs for the Egg Donor

The egg donor will not be expected to pay for any of the services or treatment regarding IVF.



PREPARATIONS FOR THE RECIPIENT / CARRIER

Screening & Requirements for the Recipient/Carrier

To be eligible to receive embryos derived from donor eggs, or a gestational carrier/surrogate must first complete the following screening tests.

Initial Interview

During this visit, the recipient meets with members of CFA's medical and nursing personnel to review all aspects of her intended testing and treatment cycle; discuss which approach is right for her; discuss the various donor/recipient matching options; and review her specific testing and treatment plan.

Physical Exam & Obstetrical/Gynecological Health

The recipient undergoes a complete physical examination including pelvic exam with Pap smear, cervical cultures, uterine evaluation (hysterosalpingogram, saline sonogram and/or hysteroscopy) and uterine mapping or "sounding". If necessary, a mammogram, EKG, colonoscopy or a medical clearance exam may also be performed. These tests are necessary to ensure a safe and healthy pregnancy.

Bloodwork

The recipient also undergoes extensive blood testing to ensure that she can become and safely remain pregnant using donated eggs. Labwork for the female partner includes: HIV-1/HIV-2, Hepatitis B Surface Antigen, Hepatitis C Antibody, RPR, Rubella, Blood type & screen, CMV, CBC, TSH and prolactin. Bloodwork for the male partner will include HIV-1/HIV-2, Hepatitis B Surface Antigen, Hepatitis C Antibody, RPR, Rubella, Blood type & Screen, CMV and a semen analysis. Genetic testing is also offered and sometimes required.



Psychological Evaluation

All recipient couples are required to meet with our psychologist. During this session, our psychologist will assess the recipient couple's psychological preparedness for the process and ensure adequate informed consent from a psychological perspective. Discussion is also focused on psychological issues that many couples who have chosen an egg donor have identified as important and helpful to address.

Getting Started

YOUR CHECKLIST

FEMALE

BLOODWORK:	DATE	RESULT
HIV-1 / HIV-2		
Hep B Surface Ag		
Hepatitis C Antibody		
RPR		
Rubella		
Blood type & screen		
CMV		
CBC		
TSH		
Prolactin		

EXAMINATIONS

GC / Chlamydia Cultures		
PAP smear		
Sonohysterogram (SHSG)		
Hysterosalpingogram (HSG)		
Office hysteroscopy		
Physical examination		
Uterine mapping		
Mammogram (>40 years old)		
EKG (>45 years old)		
Colonoscopy (>50 years old)		

MALE

BLOODWORK	DATE	RESULT
HIV-1 / HIV-2		
Hep B Surface Ag		
Hepatitis C		
RPR		
Blood type & screen		
CMV		
Cystic fibrosis screening		
Other genetic screening		

SEMEN ANALYSIS

COUNSELING	DATE	RESULT
Financial counseling		
Psychological counseling		
Meeting with physician		

CONSENT FORMS AND FINANCIAL COUNSELING

Review & Completion of Consent Forms

Consent forms must be signed before the start of any fertility medications. Prior to that we will answer any questions or medical concerns you may have, and review with you which IVF laboratory techniques are planned for you, including intracytoplasmic sperm injection (ICSI), assisted hatching, blastocyst culture and transfer, pre-implantation genetic testing (PGD) and embryo freezing.

Financial Counseling

It is essential that a recipient couple understand the financial obligation of egg donation prior to being matched to an egg donor. Our financial counselors will do everything to optimize every aspect of your insurance coverage; and to help you choose among our payment options, which require payment in full before the egg donor begins her medications. Consultation with our financial manager is therefore required to review your insurance benefits, to understand the extent of coverage available and to discuss payment policies.

For more information about Costs Related to Egg Donation, see pages 14-15,



MONITORING OF THE DONOR'S STIMULATION CYCLE

IVF with egg donation involves careful synchronization of the donor and recipient or surrogate.

Four steps are necessary.

1. Treatment of the donor with fertility medication to stimulate the growth and development of multiple follicles and eggs.
2. Removal of those eggs from the donor's ovaries.
3. Placement of the eggs and sperm together in the laboratory to achieve fertilization, followed by embryo growth under optimal culture conditions.
4. Transfer of the embryos into the recipient or carrier's uterus to establish a pregnancy.

To achieve these goals, the recipient must take medications in synchrony with the egg donor, so that the recipient's uterine lining is at the optimal stage of development when the eggs are ready for fertilization and embryos are optimal for transfer.

Even before the donor has begun her fertility medications, the carrier has been placed on other medications which are designed to "rest" her ovaries and optimize her uterine lining for implantation. After the donor begins her stimulation medications, the donor will then undergo monitoring with ultrasound and blood testing of her hormone levels to assess her response to these medications. Based on this monitoring, Dr. Doyle will adjust her dosages as needed, and also further synchronize the carrier's cycle with the donor's, to ensure that when the eggs are ideal for collection, the uterus is most suitable to receive them. Usually an egg donor produces up to 20-25 eggs, but this may vary.

Results from the recipient or carrier's ultrasound and hormone tests will be communicated directly to her. Her uterine lining (delete cavity of the donor egg recipient) is hormonally prepared prior to the embryo transfer to allow implantation to occur. Birth control pills may be used to first regulate the recipient or carrier's menstrual cycle so that it becomes physiologically synchronized with the donor's cycle. Lupron® is also used frequently to further "suppress" her hormones that may prematurely stimulate the lining of her uterus. When the recipient's hormones are appropriately suppressed, she then takes estrogen pills (Estrace®) to stimulate the uterine lining in preparation for embryo implantation. The estrogen pills are taken for at least two to four additional weeks before the transfer of the embryos, and she continues to take them following a positive pregnancy test.



MEDICATIONS

Medications & Monitoring

The uterine cavity of the donor egg recipient is hormonally prepared prior to the embryo transfer to allow implantation to occur. Birth control pills may be used to regulate the recipient's menstrual cycle so that it becomes physiologically synchronized with the donor's cycle. Lupron® is also used frequently to further "suppress" the recipient's own hormones that may prematurely stimulate the lining of her uterus. When the recipient's hormones are appropriately suppressed, she then takes estrogen pills (Estrace®) to stimulate the uterine lining in preparation for embryo implantation. The estrogen pills are taken for at least two to four additional weeks before the transfer of the embryos, and the recipient continues to take them following a positive pregnancy test.

At the time of the donor's egg retrieval, the recipient or carrier is also treated with the following medications that are designed to enhance implantation:

1. Progesterone in oil 50 mg (= 1 cc) and Prometrium® suppositories and tablets: continued until the day of the blood pregnancy test. With a positive pregnancy test, progesterone is continued throughout early pregnancy.
2. Prednisone® 10 mg: one tablet once a day for five days. Prednisone is used to theoretically prevent an immune reaction from the recipient against the embryo which might hamper implantation.
3. Doxycycline® 100 mg: one tablet twice a day for five days. Doxycycline is an antibiotic used to prevent an infectious reaction against the embryo that might also hamper implantation.
4. Baby aspirin: one tablet a day administered throughout the treatment cycle, and well into the pregnancy. Baby aspirin has a proposed role in preventing microscopic blood clots, increasing blood flow to the uterus and enhancing embryo implantation.

Preparing for the Egg Retrieval

- While the donor takes her fertility medications, she will undergo monitoring with ultrasound and blood testing of her hormone levels. Based on this monitoring, Dr. Doyle will determine how she is responding, adjust her dosages as needed, and eventually decide exactly when the eggs will be ripe for retrieval. We begin monitoring approximately 5 days after she starts her stimulation medications, and usually repeat the evaluation every 1-2 days until the egg donor is ready for the egg retrieval.
- Results from the monitoring will be communicated directly to the donor, and eventually to you. Once Dr. Doyle has decided that the egg donor is ready for her final HCG injection, the egg retrieval will be scheduled, and we will notify you and your gestational carrier. In all cases, you will be given at least 2 days notice before the retrieval will occur. **ONLY** at this time is it possible to confirm and finalize schedules for the embryo transfer. If you are using a gestational carrier, she will need to arrive no later than two days after the retrieval occurs.
- If you are planning to donate fresh semen on the day of the egg retrieval, your sexual activity and ejaculation should be timed to ensure that there has been 2-3 days of abstinence before the sperm collection.

FERTILIZATION, EMBRYO DEVELOPMENT & PGD

Fertilization and Embryo Culture

The sperm is always added to the eggs on the day of the retrieval. If a problem with fertilization is anticipated, or if poor fertilization has occurred in a previous treatment cycle, **intracytoplasmic sperm injection (ICSI)** is recommended. With ICSI a single sperm is chosen and injected directly into each egg. Once the eggs have fertilized, they are then cultured for another 2-4 days before the resulting embryos are considered ideal for transfer. At this time, the embryos are often “**hatched**”, a process which our embryologist performs to assist implantation. We generally transfer embryos on either the third or fifth day after harvesting. The pros and cons of each strategy will be discussed with you in detail once we have observed the way your embryos have developed, and the embryologist has graded their quality. Embryos can be graded based on their appearance alone, or actually biopsied for chromosomal testing using **pre-implantation genetic diagnosis (PGD)**. You should discuss with your physician whether you are a candidate for PGD based on your history or needs.

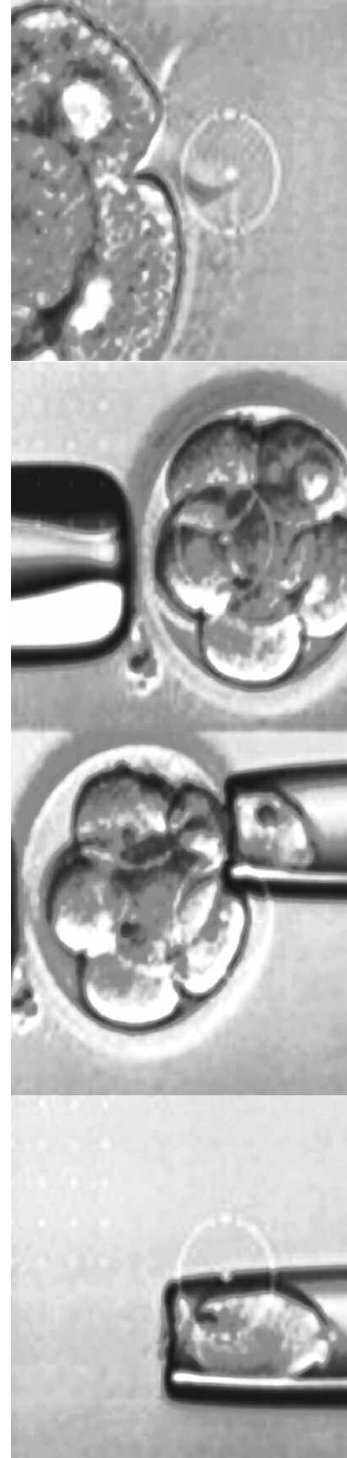
Pre-Implantation Genetic Diagnosis (PGD)

Pre-implantation genetic diagnosis (PGD) utilizes embryo biopsy to evaluate the genetic composition of your growing embryos. To do this, our embryologists routinely separate one of the cells from each embryo, which is analyzed for chromosomal testing. We can then determine the true genetics of each embryo before any pregnancy is initiated. By using this more precise information, we can distinguish those embryos that are truly perfect from others which may look good but have a chromosomal disorder that could lead to cycle failure, miscarriage or birth defects.

There are two types of tests that can be performed on an embryo: chromosomal testing (also known as aneuploidy screening) and genetic testing for a specific disease. Aneuploidy testing ensures that the embryo does not contain an abnormal number of chromosomes, which may lead to a failure of embryo growth, miscarriage, or birth abnormalities such as Down's Syndrome, a form of mental retardation.

Genetic testing can also be used to detect a specific gene defect that can be inherited from one or both parents. These defects can lead to conditions such as cystic fibrosis, sickle-cell anemia, hemophilia, Duchenne muscular dystrophy, and Tay-Sach's disease. There are many other genetic disorders for which PGD can be used, each one specific for a particular couple.

PGD may not be right for everyone, especially if you use an egg donor, so please discuss with your physician whether PGD makes sense for you.



EMBRYO TRANSFER & FREEZING

Embryo Transfer

Three to five days after the your egg retrieval (depending on your specific case), the embryos are ready for their transfer into the uterus. Which day is best for you will be determined after the laboratory team has evaluated the number and quality of your embryos.

Embryo transfer is a minor procedure requiring no anesthesia. The number of embryos to transfer is a critical decision, and this will be discussed in detail with you on the day of transfer. By this time, we can carefully look at all the embryos, and estimate the chances of pregnancy (and multiple pregnancy) based on the embryo quality. Whether it makes sense to freeze extra embryos is also discussed at this time.

Transfer of embryos usually takes about fifteen minutes. First, a speculum is placed into the vagina and the cervix is cleaned. Then a soft plastic catheter is guided into the uterus, where the embryos are placed. Ultrasound is used to guide the catheter, and to confirm that the embryos have been placed in the ideal uterine location.

After the embryo transfer

- Remain off your feet as much as possible, for 36 hours after the transfer. Keep optional activities to a minimum; but getting up for meals and bathroom visits is certainly allowed. Strict bed rest has never been proven to improve pregnancy rates.
- Resume normal diet and fluids.
- You may shower.
- Continue to take your progesterone, prednisone, doxycycline, and baby aspirin as previously directed.
- Abstain from vaginal intercourse until your pregnancy status is known.

Embryo Freezing (Cryopreservation)

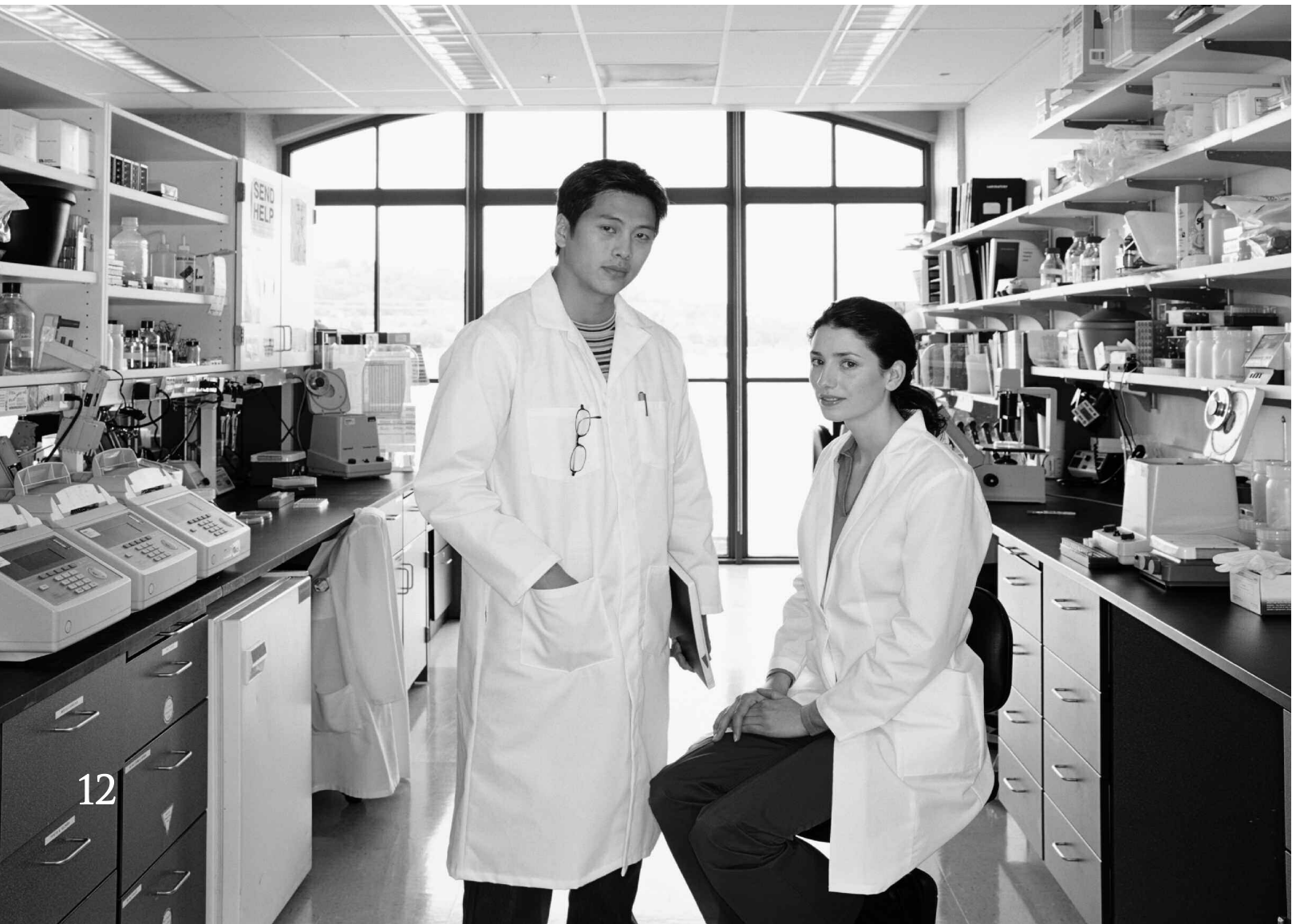
If excess embryos of very good quality exist, they can be frozen (cryopreserved), stored, and thawed at a later date, when they can be used for transfer into the uterus. Although some embryos do not survive the freezing and thawing process, those that do are returned to the uterus.

Only very high quality embryos are frozen. In other words, it is quite common to choose the very best embryos for transfer, and then evaluate the remaining “extras” to see if any are suitable for freezing. No evidence of abnormal development has been found with these embryos that survive the freezing and thawing process. Their transfer involves the same technique performed in a fresh IVF cycle, with embryos inserted through the cervix into the uterus.



COMMUNICATION FROM THE IVF LABORATORY

- We will tell you how many eggs were harvested on the day of the egg retrieval, and how the sperm looks after it is collected.
- On the following day, we will call you to tell you how many eggs have fertilized so far.
- Two days later, you will receive an update regarding the number and quality of the developing embryos, and based on the embryologist's assessment, we will decide with you when precisely the embryo transfer should occur.
- On the day of your embryo transfer, we will discuss with you how many embryos we recommend transferring, and how many "extra" high-grade embryos remain available for freezing, if that is your wish.
- Carriers should remain in Connecticut for at least 24-36 hours after her embryo transfer procedure, before she returns home. We will provide all necessary instructions and medications, and arrange for the remainder of her blood tests (one and two weeks after the egg retrieval) to occur at the lab of her choice.



FOLLOW-UP

Estrogen and progesterone levels are drawn approximately 7 days after the egg retrieval to ensure that hormone levels are optimal to allow for implantation. If they are not, dosage adjustments will be made. Even if the levels are “good”, however, it is too early to tell if pregnancy has occurred. An initial blood pregnancy test is performed 14 days after the egg retrieval. Even if bleeding has occurred, pregnancy testing still is necessary, as implantation bleeding is often mistaken for menses. It is normal to feel premenstrual and have cramping even if pregnancy has occurred.

If the pregnancy test is negative, please schedule a consultation with Dr. Doyle. This appointment is a critical part of the cycle. It gives you an opportunity to review the cycle and discuss possible recommendations for future cycles. At the post-cycle visit, we will have all of your cycle data available, so that your questions can be fully addressed at that time.

If your pregnancy test is positive, medications (estrogen, progesterone and aspirin) are continued, and we will monitor the early pregnancy very closely for approximately eight more weeks before referral to the obstetrician. This is to ensure that hormone levels increase adequately, to determine that the pregnancy develops normally, and to monitor for multiple pregnancies. While IVF pregnancies are no more likely to miscarry than other pregnancies, it is still a possibility, and the first two weeks are therefore approached with particularly “cautious optimism”. If everything proceeds normally for the two months after the egg retrieval, most of the “hurdles” have been passed, and we anticipate no problem or need for concern.



FINANCIAL CONSIDERATIONS

The breakdown of costs will be divided in to the following areas, and are exclusive of fertility medications.

Donor-Related Costs

1. Donor Screening Tests

These tests are performed to ensure that your donor satisfies all of the medical, genetic and psychological requirements to maximize your chances of having a healthy baby.

2. Cycle Management Fees and Stipend

3. Donor Monitoring Costs

Monitoring involves ultrasound and blood testing to ensure safe and optimal response to the fertility medications, and to enable dosage adjustment. Most or all of this monitoring occurs at Connecticut Fertility Associates. When necessary, monitoring can be arranged at an outside clinic.

Recipient-Related Costs

4. Mother (or Surrogate's) Screening Costs

These tests are performed to ensure that you (or your carrier) also satisfy the medical requirements to maximize your chances of a healthy pregnancy. Your insurance benefits might cover some or all of these tests. We will investigate your healthcare benefits to advise you if this is a potential.

5. Recipient Monitoring Costs

Monitoring involves ultrasound and blood testing to ensure ideal response to the fertility medications, and to choose the ideal time for embryo transfer. Most or all of this monitoring will occur at Connecticut Fertility Associates. When necessary, monitoring can be arranged at an outside clinic.

Father-Related Costs

6. Father's Screening Tests (bloodwork and semen testing)

7. Potential Sperm Preparation fees and other requirements (TESA, sperm donor)

IVF-Related Costs

IVF Medical Procedures:

Egg retrieval
Embryo transfer

IVF Laboratory Procedures:

Oocyte identification & recovery
Complex sperm prep
Fertilization by either insemination or injection of oocytes (ICSI)
Oocyte culture 1-3 days, followed by assisted hatching and/or blastocyst culture
Preparation of embryos for transfer

Additional Fees:

Cryopreservation (freezing) of excess embryos
Embryo Biopsy / PGD

RIGHTS OF THE RECIPIENT & DONOR

The intentions of the egg donor and recipient are clear and unambiguous from the outset. When the egg donor signs her consent form, she explicitly agrees that once the eggs are retrieved from her body, she waives any right to them, and relinquishes any claim to any embryos or offspring that might result from their use. The intended parents, in turn, release the egg donor from any and all liability for any problems that can occur during pregnancy; and for any mental or physical disabilities, financial support, or care, to child (ren) born as a result of egg donation. The intended parents also accept complete financial responsibility for the care and storage of any embryos frozen as a result of their treatment. The intended parents have the right to determine the fate of all embryos frozen, including but not limited to discarding them, donating them to another intended parent, or donating them for research. Anonymous donors also expect the right to privacy following egg donation. The intended parents clearly and unambiguously agree not to seek the identity of the egg donor in the present or future if the donation was anonymous.

Anonymity & Privacy

Data from your assisted reproductive technology (ART) procedure will be provided anonymously to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that CDC collect data on all ART cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, CDC applied for and received an “assurance of confidentiality” for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that CDC has that identifies you will not be disclosed to anyone else without your consent.



the Egg Donation team at
CONNECTICUT FERTILITY ASSOCIATES

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**Meet CFA's
 Donor/Surrogacy
 Team**

Michael Doyle, M.D.
Medical Director



Clinical Coordinators
 Sharron Steere, RN
Nurse Coordinator



Lorrie Mirizio
Cycle Coordinator



Colleen Iversen
Surrogacy Coordinator



Sandy Laucella
Donor Coordinator



Jamie Speer, MS
Genetic Counselor



Kathy Fontan
Program Administrator

FREQUENTLY ASKED QUESTIONS

Q: Does your office have a pool of recruited donors?

A: A list of donors is available on our Web site: PreciousStart.com or at www.CTfertility.com, under the Egg Donation section.

Q: Do you offer several third-party broker sources or do you have a contract with one third-party broker?

A: CFA works with several third party brokers.

Q: Will you assist us in recruiting our own donor?

A: Yes.

Q: What is the age range of your recruited donors?

A: Donors are between 21 and 32 years of age.

Q: Will your donors be anonymous or will they be known to us?

A: All CFA donor recruits remain anonymous at all times, however many share photographs of themselves as children or younger adults.

Q: If your general policy is to recruit only anonymous donors, are you open to recruiting a donor we can meet?

A: Typically, we only recruit anonymous donors but we would be willing to help to assist recipients if they desire a known donor.

Q: How accessible is the donor's pertinent medical history to the recipient couple? How long do you keep the records?

A: Records are held in archives after donation is complete. During the donor search, the recipient views an extensive application, which the donor has completed prior to her acceptance into the program.

Q: Do you accept relatives and friends of the recipient couple into the program if we wish to have a known donor?

A: Yes.

Q: Do you accept donors recruited by a third-party broker?

A: Yes.

Q: Do you allow the donor and recipient to remain anonymous if they desire?

A: Yes.

Q: What is your screening process for recruited donors? Is the screening similar or different with relatives, friends or third-party recruited donors?

A: All donors undergo extensive testing including a physical examination, blood work for overall health, infectious diseases and genetic testing and psychological counseling.

Q: How long do we have to wait for a recruited donor?

A: Depending on your needs, donors are available for immediate matching and after the screening is complete, the cycle can usually begin within two months.

Q: What kind of flexibility do we have in selecting a recruited donor? Can we choose from a file of donors? Can we see pictures, or read a short history about each prospective donor?

A: Yes, an extensive file is available to review. Pictures are sometimes also available if the donor is willing. More often, donors may opt to share baby pictures of themselves; or if they have their own children, pictures of their baby or babies.

Q: Do you work with sperm banks to provide donor sperm if there is a male factor?

A: Yes.

Q: Does your program operate year round? How many doctors and nurses are there in the practice?

A: Yes, our practice is open year-round, 365 days a year and consists of our team of lead physicians, nurse practitioners, egg donor coordinators and two IVF nurse coordinators.

Q: Is your office a member of the Society for Assisted Reproductive Technology?

A: Yes.

Q: Do you have the capacity and experience to freeze extra embryos?

A: Yes.

GLOSSARY

of frequently used terms

Adhesion: The scar tissue that forms around reproductive organs following a previous injury, infection or surgery.

Androgen: Primarily a male sex hormone, found in the ovaries.

Assisted Reproductive Technologies (ART): A variety of procedures used to bring about conception without sexual intercourse, including IVF, and GIFT.

Baseline ultrasound: An examination conducted before starting therapy to determine the general position and condition of the ovaries.

Blastocyst transfer: A recent advance in infertility treatment, in which embryos develop for 4 or 5 days (until they reach blastocyst stage), rather than the usual 2 or 3 days in IVE.

Cervical mucus: Mucus produced by the cervix that permits passage of sperm during ovulation, and prevents infection.

Cervix: Lower section of the uterus that protrudes into the vagina, through which the sperm pass to reach the uterus.

Chemical pregnancy: The false appearance of pregnancy due to changes in hormonal levels.

Conception: Fertilization: When the sperm meets and penetrates the egg.

Controlled ovarian hyperstimulation: Stimulation of the ovaries with various hormonal medications in order to develop as many follicles as possible, as well as to control the timing of ovulation.

Corpus luteum: A structure that forms at the site of an ovarian follicle after it releases an egg. The corpus luteum releases estrogen and progesterone, two hormones necessary for maintaining a pregnancy. If pregnancy occurs, the corpus luteum functions for five or six months. If pregnancy does not occur, it stops functioning.

Cryopreservation: Storage of organs or tissues at very low temperatures. Embryos that are not used in an ART cycle can be cryopreserved for future use.

Dysmenorrhea: Cramping and pain around the time of menstruation.

Dysmucorrhea: Poor quality or inadequate cervical mucus that can prohibit sperm passage.

Ectopic pregnancy: The implantation of an embryo in a place other than the uterus.

Egg retrieval: A procedure used to obtain eggs from ovarian follicles for use in in vitro fertilization. The procedure may be performed during laparoscopy or through the vagina by using a needle and ultrasound to locate the follicle in the ovary.

Ejaculate: As a noun, it refers to the mixture of sperm and seminal fluid that comes out of a man's penis during sexual stimulation. As a verb, it refers to the passing of this material.

Endometrial biopsy: The removal of a sample of the lining of the uterus for examination.

Endometriosis: A disease whereby cells lining the uterus (or endometrium) get outside of the uterus and stick to other organs, causing inflammation.

Endometrium: The lining of the uterus.

Embryo: Term used to describe the early stages of fetal growth, from conception to the eighth week of pregnancy.

Embryo transfer: Placing an egg fertilized outside the womb into a woman's uterus or fallopian tube.

Estradiol: The most potent naturally occurring estrogen in humans, which is released from the ovary.

Estrogen: Hormone that stimulates secondary female sexual characteristics and controls the course of the menstrual cycle. Also produced in low quantities in males.

Fallopian tubes: Ducts through which eggs travel to the uterus once released from the follicle. Sperm normally meet the egg in the fallopian tube, the site at which fertilization usually occurs.

Fertility specialist: A physician specializing in the practice of fertility. The American Board of Obstetrics and Gynecology certifies a subspecialty for OB-GYNs who receive extra training in reproductive endocrinology (the study of hormones) and infertility.

Fertility treatment: Any method or procedure used to enhance fertility or increase the likelihood of pregnancy, such as ovulation induction treatment, varicocele repair (repair of varicose veins in the scrotal sac), and microsurgery to repair damaged fallopian tubes. The goal of fertility treatment is to help couples have a child.

Fertilization: The combining of the genetic material carried by sperm and egg to create an embryo. Normally occurs inside the fallopian tube (in vivo) but may also occur in a Petri dish (in vitro). (See also *In Vitro Fertilization*, www.seronofertility.com/ui_glossary.jsp#inVitroFertilization > .)

Fibroid tumor: Benign (not malignant or life-threatening) tumor of fibrous tissue that can occur in the uterine wall. May be totally without symptoms or may cause abnormal menstrual patterns or infertility.

Follicles: Fluid-filled sacs in the ovary, which contain the eggs released at ovulation. Each month an egg develops inside the ovary in a follicle.

Follicle Stimulating Hormone (FSH): A pituitary hormone that stimulates follicular development and spermatogenesis (sperm development). In the woman, FSH stimulates the growth of the ovarian follicle. In the man, FSH stimulates the Sertoli cells in the testicles and supports sperm production. Elevated FSH levels are associated with gonadal failure in both men and women.

Gamete: A reproductive cell. Sperm in men, the egg in women.

Gonadotropins: Hormones that control reproductive function: Follicle Stimulating Hormone and Luteinizing Hormone.

Gonadotropin Releasing Hormone (GnRH): A substance secreted every ninety minutes or so by a part of the brain called the hypothalamus. This hormone enables the pituitary to secrete LH and FSH, which stimulate the gonads.

Human Chorionic Gonadotropin (hCG): The hormone produced in early pregnancy that keeps the corpus luteum producing progesterone. Also used via injection to trigger ovulation after some fertility treatments, and used in men to stimulate testosterone production.

Hypothalamus: The gland at the base of the brain that controls the release of hormones from the pituitary glands.

Hysteroscopy: A visual examination of the uterus using an instrument called a hysteroscope, which enables the doctor to see into the organ without making a large incision.

Idiopathic infertility: The term used to explain when the cause of infertility cannot be explained.

Infertility: The inability to conceive after a year of unprotected intercourse (six months if the woman is over age 35) or the inability to carry a pregnancy to term.

Implantation (Embryo): The embedding of the embryo into tissue so it can establish contact with the mother's blood supply for nourishment. Implantation usually occurs in the lining of the uterus; however, in an ectopic pregnancy it may occur elsewhere in the body.

Intracytoplasmic Sperm Injection (ICSI): A micromanipulation (occurring under the microscope) procedure in which a single sperm is injected directly into the egg to enable fertilization with very low sperm counts or with non-motile sperm (sperm that don't swim effectively toward the egg). The embryo is then transferred to the uterus.

Intramuscular (IM) needle: A needle designed to administer medication deep into the muscle. Injections of this type are usually given in the thigh or upper buttock area.

In Vitro Fertilization (IVF): Eggs produced by administering fertility drugs are retrieved from the woman's body and fertilized by sperm in a laboratory. The resulting embryos are transferred by catheter to the uterus.

Luteal phase: Days of the menstrual cycle after ovulation when progesterone is produced by the corpus luteum.

Luteinizing Hormone (LH): A pituitary hormone that stimulates the gonads. In the man, LH is necessary for spermatogenesis and for the production of testosterone. In the woman, LH is necessary for the production of estrogen.

Luteinizing Hormone Surge (LH SURGE): The release of luteinizing hormone (LH) that causes release of a mature egg from the follicle.

Micromanipulation: A variety of techniques that can be performed in a laboratory under a microscope. An embryologist manipulates egg and sperm to improve the chances of pregnancy. (See Intracytoplasmic Sperm Injection, ICSI. http://www.serofertility.com/ui_glossary.jsp#ICSI)

Miscarriage: Spontaneous loss of a viable embryo or fetus in the womb.

Morphology: The physical structure and configuration of sperm cells. The ability of sperm to swim. Poor motility means the sperm have a difficult time swimming toward the egg.

Oligospermia: Abnormally low number of sperm in the ejaculate of the male.

Oocyte: The egg.

Ovarian hyperstimulation syndrome (OHSS): A painful condition caused when the ovaries become overstimulated by the various hormones that cause follicular development.

Ovaries: The two sexual glands of the female where the eggs are stored. The ovaries also produce the hormones estrogen and progesterone.

Ovulatory dysfunction: A problem with the ovary where the egg is not matured or released properly.

Ovum: The egg.

Pituitary gland: The gland located at the base of the brain that secretes a number of important hormones that regulate fertility, as well as normal growth and development of the body.

Polycystic ovarian syndrome (PCOS): The formation of cysts in the ovaries that occurs when the follicle stops developing. This is due to a hormonal imbalance in the ovary.

Post-coital test (PCT): A test to determine whether the sperm can move properly through the cervical mucus.

Progesterone: The hormone produced by the corpus luteum during the second half of a woman's cycle. It thickens the lining of the uterus to prepare it to accept implantation of a fertilized egg.

Sperm (spermatozoa): The microscopic cell that carries the male's genetic information to the female's egg; the male reproductive cell; the male gamete.

Sperm count: The number of sperm in an ejaculate. Also called sperm concentration and given as the number of sperm per milliliter.

Subcutaneous (SC) needle: A needle designed to administer medication just below the surface of the skin, into the fatty tissue.

Testosterone: The male hormone responsible for the formation of secondary sex characteristics and for supporting the sex drive. Testosterone is also necessary for spermatogenesis (sperm development).

Tubal pregnancy: The development and attachment of a fertilized egg in a fallopian tube.

Ultrasound: A test used instead of X-rays to visualize the reproductive organs; for example, to monitor follicular development.



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