INFORMED CONSENT FOR PLATELET RICH PLASMA (PRP) ENDOMETRIAL INFUSION

Platelet Rich Plasma, also known as “PRP”, is a treatment in which a person’s own blood rich in platelets is, used to aid in the enhancement of the uterine lining prior to embryo transfer. The blood will be drawn in our office using the same technique as having it drawn for routine lab testing. It is centrifuged to separate its different components in the blood to extract the most concentrated “Platelet rich” portion of the plasma. Platelets are very small cells in your blood that are involved in the clotting and healing process and have “regenerative” properties. When PRP is injected into the damaged area, it causes a mild inflammation that triggers a healing cascade. As the platelets organize in the treatment area, they release several enzymes to promote healing and tissue responses, including attracting stem cells and releasing growth factors to repair damaged tissue. As a result, new collagen and elastic fibers begin to develop, or a regenerative process. PRPs safety has been established for over 20 years for its use wound healing properties. Its proven effectiveness has extended across multiple medical specialties. Several studies have shown an improvement in the implantation rate after embryo transfer

CONTRAINDICATIONS

Persons with the following conditions are not considered candidates:

- Acute or chronic infections
- Abnormal platelet function or blood disorders
- History of Allergic reaction to blood products
- Any severe metabolic or systemic disease

RISKS AND COMPLICATIONS

Potential side effects include:

- Pain, bleeding, and/or bruising at the blood drawing site
- Possible uterine irritation and/or associated cramping/spotting
- Pelvic Infection

GENERAL CONSENT FOR PLATELET RICH PLASMA (PRP) INJECTION

My consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to the physician to perform Platelet Rich Plasma (aka PRP) infusion to the endometrial cavity as discussed during our consultation, for the purpose of improving endometria implantation I have read this informed consent and certify I understand its content in full. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have been instructed in and understand post treatment instructions. I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment. I also understand this procedure is "elective" and not covered by insurance and that payment is my responsibility. Any expenses which may be incurred for medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome, will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable.

Information and Informed Consent

I hereby give my voluntary consent to this PRP procedure and release Boston IVF, its medical staff, and specific technicians from liability associated with the procedure.

I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form shall be binding upon spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that if I should have any questions or concerns regarding my treatment results, I will notify Boston IVF and/or the provider immediately so that timely follow-up and intervention can be provided.

PROVIDER ATTESTATION

I have explained the procedure(s), alternative(s), and risks to the person or persons whose signature is affixed above. The patient has verbally communicated to me that they understand the contents of this form.

_____ / _____

Patient Signature Date

_____ / _____

Provider Signature Date