



Boston IVF

IVF TREATMENT GUIDE

What Every Patient Should Know

BOSTON IVF-Brookline
One Brookline Place
Brookline, MA 02445
Tel. (617) 735-9000

BOSTON IVF-Maine
778 Main St
So. Portland, ME 04106
Tel. (207) 358-7600

BOSTON IVF-South Shore
2300 Crown Colony Drive
Quincy, MA 02169
Tel. (617) 793-1100

BOSTON IVF-Waltham
130 Second Avenue
Waltham, MA 02451
Tel. (781) 434-6500

BOSTON IVF-Worcester
338 Plantation St
Worcester, MA 01604
Tel. (508) 751-8050

Providence RI Center
49 Seeknot Street
Providence, RI 02906
Tel. (401) 369-7822

www.bostonivf.com

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This guide will provide you with an understanding of the treatment that has been recommended by your physician. The information in this guide adds to the discussions you have had with your Boston IVF physician. Boston IVF wishes you quick and positive results.

BEFORE STARTING TREATMENT

There are several steps that must be completed before the treatment can be started.

- **Medical Evaluation**
Prior to starting treatment, all testing ordered by the physician must be completed. At the consultation the physician will review the test results and discuss the treatment in detail.
- **Visit our website (www.bostonivf.com)**
Our website has a number of documents that will help you get started. Go to our website (www.bostonivf.com) and click the “for patients” button—type in the *username* **bostonivf** and the *password* **patient**. The following documents can be printed off- cycle calendar and consent forms.
- **Orientation & Injection Teaching**
Please go to www.bostonivf.com scroll down to the bottom of the website and you will see on the right had side the link for **Village Pharmacy** and **Freedom pharmacy**. There is no passcode needed to access the websites, just click right in, to watch the videos on your specific medications.

Please contact patient educational services at **781-434-6524** several weeks before you plan to start treatment to learn more about the treatment and the injections.

- **Consent Form**
Consent forms can be downloaded from our website. All consent forms must be signed and witnessed by one of our clinical staff prior to the initiation of treatment. The forms can be downloaded from our website. Please call your clinical assistant to arrange signing of the consent forms if they have not been signed already.
- **Insurance Authorization**
Prior to initiation of the treatment, insurance approval must be in place. We will work with you to get approval for the treatment. It may take several weeks to get the final approval from your insurance company.

For your convenience we have produced a separate booklet that describes the insurance process in Massachusetts. Information in the booklet may prove useful

to patients who live in other states as well. The booklet is available on-line at www.bostonivf.com/documents.

GETTING READY FOR A PREGNANCY

At Boston IVF, our goal is to not only help you achieve a pregnancy, but to have a healthy pregnancy, as well. There are certain things that you can do to achieve this goal.

Smoking

If you smoke, you must stop! The bad effects of smoking on general health are well known (e.g., heart disease, cancer and chronic lung disease). Women who smoke during pregnancy are at increased risk of complications. Men and women who smoke have decreased fertility. Studies suggest a link between parental tobacco use during and after pregnancy and an increased risk of childhood cancers in their offspring. If you can't stop smoking on your own then you should contact your primary care physician.

Alcohol

Alcohol intake can impair male and female fertility. Women trying to conceive should completely avoid alcohol or limit use to the first 2 weeks of the menstrual cycle. During pregnancy alcohol is absolutely contraindicated.

Caffeine Intake

Caffeine's affect on fertility has been the subject of controversy. Several studies have concluded that caffeine decreases the chance of conceiving. However; a cause and effect relationship between caffeine intake and fertility has not been absolutely confirmed. Nevertheless, it is reasonable to suggest that women discontinue or at least limit their intake to one caffeinated beverage a day.

Drug Use

The use of recreational drugs is contraindicated while attempting to conceive and during pregnancy. Some drugs, such as marijuana, may decrease sperm concentration and testosterone hormone production in men.

Diet

Ingestion of some fish, which contain higher amounts of mercury, can affect the development of the nervous system of a fetus. During the treatment and after pregnancy is established you should avoid eating these fish- shark, swordfish, king mackerel, tilefish and canned tuna fish. You should limit the intake of all other fish to 12 oz. per week.

Vitamin Supplementation

Folic acid supplementation can significantly reduce the occurrence of neural tube defects in infants. Neural tube defects are abnormal developments of the spine and skull. All women should take at least 0.4 mg of supplemental folic acid per day. This can be accomplished either through dietary supplementation or by taking an over-the-counter multivitamin (or prenatal vitamin).

Excessive intake of vitamin A increases the chance of congenital anomalies. Prenatal vitamins and over-the-counter multivitamins usually contain 5,000-8,000 IU of vitamin A, which is a safe dose. However, your daily intake should not exceed 8,000 IU.

Routine medical care

You should have a yearly visit with your primary care physician or gynecologist for a routine exam. Your yearly exam should be faxed to your nurse, prior to treatment. A pap smear must be up to date at the recommendation of your doctor. A baseline mammogram to screen for breast cancer should be performed between ages 35-40 and after age 40 the mammogram should be done every other year. If the Pap smear is not up-to-date or you need to schedule a mammogram, you should contact your gynecologist or primary care physician.

Exercise

The benefits of exercise on general health and mental well being are well established. Further, moderate exercise during pregnancy is also beneficial. If you were already in an exercise program, we would encourage you to continue. However, the medications used to stimulate the ovaries can cause ovarian cyst formation and ovarian enlargement. Therefore, we would advise you to avoid high impact exercises such as running and kickboxing. Other exercise activities such as swimming, bicycle riding, walking, using the treadmill or elliptical are acceptable. We consider this low impact, (you should be able to carry out a conversation easily while exercising).

Medication Use

All non-fertility medications that have been prescribed should be discussed with your physician. It is also important that your physician who originally prescribed these medications be made aware that you are attempting pregnancy. You should avoid taking aspirin and aspirin-like compounds (such as Advil®, Aleve®, Ibuprofen, Motrin®) around mid-cycle, since these medications can interfere with ovulation. Tylenol® is a suitable alternative.

INSURANCE COVERAGE

Prior to treatment it is essential that you determine the extent of insurance coverage that is in place. To understand this better please read below:

- **Speak with one of our financial counselors**-we have experienced financial counselors who will investigate the extent and any limitations in your insurance coverage. Different forms of treatment require different levels of insurance company authorization.
- **It can take some time**- your insurance company may require specific information or testing prior to authorizing treatment. This is in addition to and separate from any referrals that are issued by your primary care physician. Please realize that obtaining insurance authorization can sometimes take 2 to 4 weeks. Pre-planning on your part can help avoid frustrating delays in treatment.
- **If you change your insurance plan**-If you are changing insurance plans it is critical that you notify our financial counselors immediately. Sometimes a

change in insurance policies will delay initiation of treatment. Fortunately, you can minimize and often avoid these delays entirely by giving a copy of your new insurance card (both sides) to our financial counselors and your Boston IVF doctor's secretary.

- **Go to our website to learn more-**A more comprehensive discussion about insurance and fertility treatment can be found in the Boston IVF publication *"Guide to Infertility Insurance Coverage"* available on-line at www.bostonivf.com. Go to our website and click on "for Patients" button on the top right hand side. Log in with the username "*bostonivf*" and password "*patient*".

COUNSELING AND SUPPORT: WHEN AND WHERE TO FIND IT

Few situations in life are as challenging, demanding and stressful as infertility and its treatment. Patients often express a sense of loss of control over their lives when pregnancy does not come quickly. Multiple tests and office visits can compound the anxiety for some patients.

Boston IVF offers counseling for individuals and couples with professionals who specialize in fertility issues. Our goal is to help patients sort out their feelings, identify coping strategies and to feel better about themselves during their fertility treatment.

OUR COUNSELING STAFF

Jeanne Ungerleider, LICSW	617-739-4791 ext. 201 or 617-487-6821
Terry Chen Rothchild, LICSW	617-964-6626
Lynn Nichols, LICSW	978-369-2390

THE DOMAR CENTER FOR MIND/BODY HEALTH

The Domar Center at Boston IVF in Waltham offers multiple resources for patients. These services include mind/body groups, acupuncture (offered seven days per week, plus weekday evenings), nutritional counseling, individual and couples counseling, treatment for eating disorders, and yoga classes.

Recent research has shown that anxiety, depression and stress, can make it difficult to focus on treatment. Reducing stress is associated with higher pregnancy rates. Boston IVF feels strongly about the services that are offered through The Domar Center.

One way to determine the best way for you to reduce your stress level is to come in for a mind/body consultation. This 45 minute visit with a psychologist, normally covered by your health insurance, is designed to assess your current physical and psychological health as well as your symptoms. The goal of the visit is to come up with a treatment plan tailored specifically to you. This might mean simply continuing to see that psychologist, who can support you during your infertility journey and teach you stress-reducing strategies, or it might be a combination of services, such as acupuncture to enhance your fertility and nutrition counseling to guide you toward healthier eating habits. You can call the Domar Center for more information about the mind/body consult, or to make an appointment for any of the services at 781-434-6578. Also you can visit our website: www.domarcenter.com to learn more about our services.

ADDITIONAL SUPPORT

Resolve New England

395 Totten Pond Rd

Suite 403

Waltham, Ma

Tel: 781-890-2250

www.resolvenewengland.org/

IVF TREATMENT

In Vitro Fertilization (IVF) is a treatment that helps an infertile woman achieve a pregnancy. The treatment involves four main steps: 1) the woman takes injections to stimulate the ovaries to produce follicles which are the fluid filled cysts in the ovaries that contain the eggs; 2) the removal of eggs from her ovaries by an ultrasound guided procedure performed under anesthesia; 3) the placement of the eggs and sperm together in the laboratory to allow fertilization to occur, and; 4) the transfer of fertilized eggs (embryos) into the woman's uterus for the establishment of pregnancy. All of the steps will be described in detail.

MEDICATIONS USED FOR OVARIAN STIMULATION

Medications are administered to increase the number of eggs that are produced in the ovaries. To get a better understanding as to how these medications work it is worthwhile to provide you with a quick review what happens naturally.

The eggs are present in the ovaries within fluid-filled cysts called follicles. During a woman's menstrual cycle, usually one mature follicle develops, which results in the ovulation of a single egg. Several hormones including follicle stimulating hormone (FSH) and luteinizing hormone (LH) influence the growth of the ovarian follicle. These hormones are produced by the pituitary gland, which is located at the base of the brain. FSH is the main hormone that stimulates the growth of the follicle, which produces an

estrogen hormone called *estradiol*. When the follicle is mature, a large amount of LH is released by the pituitary gland. This surge of LH helps to mature the egg and leads to ovulation 36-40 hours after its initiation.

There are several types of medications that can be used to stimulate the ovaries which are described below.

Injectable Medications

Gonadotropins - gonadotropins are injectable medications commonly prescribed to stimulate the ovaries of women undergoing IUI treatment. All of these medications are subcutaneous (administered with a small needle under the skin). As part of the orientation process we will make sure you feel comfortable with administration of the injections.

- FSH (*Gonal-F*[®], *Follistim*[®], *Bravelle*[®]) - These medications contain only FSH and are administered on a daily basis by injection.
- Human Menopausal Gonadotropins (*Menopur*[®])(*Low Dose hCG*)- These medications contain equal amounts of FSH and LH, and are administered on a daily basis by injection.

Human Chorionic Gonadotropin (HCG)

Human chorionic gonadotropin or hCG mimics the natural LH surge that leads to ovulation. HCG is available as a urinary extract under the brand names Novarel[™], Pregnyl[®] or Profasi[®] or in recombinant form, Ovidrel[®].

Lupron Trigger- This medication is used to cause the body to ovulate.

GnRH Agonists

These medications are used to help get better control of the cycle and prevent premature ovulation. The most commonly prescribed medication is Lupron[®] (given by injection).

GnRH Antagonists

Cetrotide[®] 0.25 mg is used for daily subcutaneous injection. Ganirelix is available at a dose of 250 mcg (prefilled syringe) for daily subcutaneous administration.

Other Medications

Some women may benefit from other medications given during the stimulation phase of treatment while others may require supplementary medications after ovulation. The following list covers the most common adjunct medications prescribed during ovulation induction therapy.

Insulin Sensitizers

Insulin sensitizers are agents commonly used in women who have polycystic ovarian disease. The most common insulin sensitizers available today include Glucophage® (Metformin), Avandia® (Rosiglitazone) and Actos® (Pioglitazone). Of these three, Glucophage has the longest track record of success and is the most commonly prescribed.

Progesterone

Progesterone may be offered to some patients following ovulation. Progesterone can be administered vaginally (Crinone®, Prometrium®, Endometrin®, pharmacy compounded suppositories) or by intramuscular injection. Store at room temperature.

Storage of Medications

Cartridge and Pen Medication- Follistim® (Cartridge) Gonal f Pen

These medications are good till the expiration date when refrigerated. If kept At room temperature protected from light they are good for three months. When Using these medications they are only good for 28 days regardless if Refrigerated or kept at room temperature protected from light.

Powdered Medication- Bravelle®, Menopur®

Lyophilized powder may be stored refrigerated or at room temperature 36°-77° Protect from light. Use immediately after reconstitution. Discard unused material. Follistim AQ-Cartridges should be stored in your refrigerator until ready to use.

Lupron

Lupron® 2 week kit: Store in refrigerator- needs to be protected from light and heat. Keep below 77°F. Protect from light.

Cetrotide/Ganirelix

Protect from light. Store Cetrotide 0.25 mg vials in the refrigerator (keep from freezing). Do not store in the bathroom, near the kitchen sink, or in other damp places. Store Ganirelix® at room temperature.

Administration of Injections

You will speak with our patient liaison to learn more about the treatment and discuss how to administer the injections. Please contact patient educational services at **781-434-6524** several weeks before you plan to start treatment. To learn more about injections we encourage you to visit a number of websites that are informative:

➤ **Orientation & Injection Teaching**

Please go to www.bostonivf.com scroll down to the bottom of the website and you will see on the right had side the link for **Village Pharmacy** and **Freedom**

pharmacy. There is no passcode needed to access the websites, just click right in, to watch the videos on your specific medications.

Administration of subcutaneous injection

1. Choose an injection site
 - fold of abdomen 2 inches parallel to or below the belly button
 - Side of upper thigh
2. Swab the area with alcohol. Allow the area to dry. Avoid any area that has a bruise, mole or obvious blood vessels. Some patients have reported less stinging, burning, and redness when they use the abdomen.
3. When the site is dry, pinch a fold of skin. If using the abdominal site, use the area two (2) inches to the right or left of the belly button. If using the thigh, use the upper outer portion of your thigh. Do not use the inner thigh area.
4. Use your other hand to insert the needle straight into the injection site.
5. Release the pinch and slowly depress the plunger all the way and remove the needle.
6. Use a clean gauze pad to stop any bleeding that may occur.

Cycle Monitoring

In order to monitor the response of the ovaries to gonadotropins, ultrasound examination of the ovaries and/or measurement of blood hormone levels are performed. Certain patients may avoid blood testing with the use of **salivary estrogen measurements**. When performing salivary testing your nurse would provide you with a collection kit, sample will be provide and dropped off to the phlebotomy. Your nurse will give you specific instructions in regards on how to provide the sample. The number of ultrasound examinations and blood tests varies from cycle to cycle. The average number of tests per cycle is 3-4.

The ultrasound examination is done using the vaginal ultrasound technique. A vaginal probe is placed into the vagina and visualization of the ovaries is obtained. The ultrasound measures the follicles, which are fluid-filled cysts in the ovaries in which the egg develops. The size of the follicle is related to the maturity of the egg. The number and size of the follicles are recorded by ultrasound. The objective is to obtain a number of follicles of sufficient diameter to result in a mature egg. A mature follicle is between 15-22 mm in diameter. Since the ultrasound is performed transvaginally, there is no need for a full bladder.

In addition to the ultrasound examination, blood tests are sometimes performed to measure blood hormone levels, including estradiol (estrogen). Certain patients may have salivary (painless) estrogen measurements, as opposed to blood testing. The developing follicles produce estradiol in response to gonadotropins. Therefore, estradiol

determinations allow your physician to obtain further information about ovarian response. You will be given an appointment for your blood test and ultrasound examination. The ultrasounds and blood tests are scheduled early in the morning so the results can be reviewed by your physician in the early afternoon.

CYCLE CANCELLATION

About 15 percent of patients who begin taking medication are canceled prior to the egg retrieval. Some of the reasons for cycle cancellation are: 1)the follicles are not developing properly, 2)inadequate blood hormone levels, 3)premature ovulation, and 4)less than three follicles maturing simultaneously. If a cycle is cancelled, medication may be modified in subsequent cycles in an attempt to improve your response. Such issues are discussed by the physician during the postoperative visit. Ordinarily, the month after a cancelled treatment plan is used to allow a medication “washout”. It is during that month when you will meet with your physician to plan future therapy.

You will be instructed to call your physician’s administrative assistant in the event of cancellation so as to schedule a visit to review the cancelled cycle and plan the next treatment cycle. Beginning the next cycle often requires taking birth control pills for approximately two weeks before starting gonadotropins, or waiting a month for a “medication washout” period. You will meet with your physician before starting gonadotropins. Insurance approval is also required, and your treatment protocol will be submitted to your insurance company at the time of the visit with your physician.

Occasionally, the estradiol (E2) level is too high and the risk of hyperstimulation may be Aggravated if a pregnancy does occur. In such cases, we may recommend that all the embryos be frozen, and possibly transferred a month or two later. If it is necessary to freeze all embryos because of the high risk of hyperstimulation, we would also recommend avoiding intercourse as well.

THE EGG RETRIEVAL

The egg retrieval is the second step of the IVF treatment. The egg retrieval is an outpatient procedure performed at our surgical center in our Waltham and Portland facility. The procedure is accomplished under vaginal ultrasound guidance under anesthesia. For this procedure, the woman is placed in the same position as if she was having a pelvic exam. After the anesthesia is given, the vagina is cleaned with a saline solution. The vaginal ultrasound probe is then placed in the vagina allowing visualization of the follicles within the ovaries. Under ultrasound guidance, a small needle is passed through the vaginal wall and into the ovarian follicles. Fluid is aspirated from the follicles and then examined by a biologist to determine if eggs are present. During the egg retrieval, follicles from both ovaries are aspirated. The procedure is usually completed within twenty minutes. The complication rate following an egg retrieval is less than 1%. Complications may include pelvic infection, bladder infection, injury to the intestines and injury to blood vessels. Any of these complications and others could require a hospitalization and, possibly, additional medical and/or surgical treatment that could impair or prevent the chances of achieving pregnancy in the future. In rare instances, it

may be necessary to remove one or both ovaries or perform a hysterectomy. An antibiotic is administered prior to the performance of the egg retrieval to reduce the chance of an infection. A side effect of this medication could be an allergic reaction.

Pre-Egg Retrieval Instructions

The following instructions are important to remember in preparing for your egg retrieval:

1. Do not take products such as Ibuprofen (Motrin®), Advil®, Aleve® and Naproxen since they can interfere with blood clotting. You may take Acetaminophen (Tylenol®).
2. Complete the on-line medical history at www.onemedicalpassport.com
3. Do not eat or drink after midnight the night before the egg retrieval.
4. Please listen to the instructions on the pre-recorded line 781-434-6577
5. Arrange for a ride home after the egg retrieval in the company of a responsible adult.
6. A responsible adult should be with you for 24 hours after the egg retrieval.
7. Leave valuables such as jewelry (including wedding bands), money, eyeglasses and credit cards at home.
8. If you have any piercing jewelry it must be removed prior to the egg retrieval.
9. Bring a small bag for personal belongings.

Day of Egg Retrieval

Arrive at Boston IVF at the designated time and check in with the receptionist. Boston IVF loves children but if you are fortunate to be parents, we politely request that you refrain from bringing them to your surgical procedure as a courtesy to other patients. We thank you for your understanding and cooperation.

A nurse will soon call you to take your vital signs and help prepare you for the procedure. Next, the anesthesiologist explains the anesthesia to be used and answers any questions. Lastly, you meet with the Boston IVF physician who will perform the procedure. When you are ready to be escorted into the operating room, an intravenous (IV) will be started to administer anesthesia to you.

(Please note: The Boston IVF physician performing procedures on the day of your egg retrieval may not be your own personal physician. The attending physician will be able to answer questions of a general nature but we recommend that you thoroughly discuss your treatment plan with your own doctor well in advance of the procedure.)

Sperm Preparation

On the day of the egg retrieval, a sperm sample is obtained. It is our policy that the male partner must deliver the sperm sample to the lab. Under some circumstances, sperm can be frozen prior to the day of egg retrieval for use on the day of egg retrieval.

Reasons to consider sperm freezing would be if the male partner may not be available on the day of the egg retrieval or there has been difficulty in the past with the production of a semen sample. You are responsible for making arrangements to freeze sperm prior to the start of treatment if this applies to you. The source of the sperm can be from the male partner or in some situations the couple (patient) may choose to use donor sperm.

Semen Collection Instructions

1. Abstain from ejaculation from the time your partner takes the hCG (this is the final injection that is administered 2 days prior to the egg retrieval). Abstinence for more than one week prior to the day of your egg retrieval is discouraged.
2. Semen samples are produced by masturbation. Sterile specimen containers should be obtained from Boston IVF, you can pick up at any BIVF Center. Samples collected in non-sterile containers cannot be used due to the risk of bacterial contamination.
3. If using a fresh sample from your partner for your IVF cycle you will be given a time for him to produce or drop off the sample. If producing at home your partner will need a sterile specimen contain cup, which you can pick up at our Boston IVF sites. Your partner should have a picture ID on him. Your partner can always arrive earlier than the time he is given but not later.
4. Please wash your hands before collection, making sure to remove all soap afterwards. Be certain not to touch your mouth, nose or rectal area after you have washed your hands since this could contaminate the semen with bacteria.
5. Do not use saliva, oils or lotions as a lubricant. If a lubricant is needed, please only use plain glycerin, this can be purchased at your local pharmacy.
6. It is best if you produce the semen sample at our Waltham site. However, if you live within a 60 minute drive of Boston IVF, you may produce your specimen at home. Please be sure not to expose the sample to excessive heat or cold by keeping it close to your body (in a shirt pocket or inside your shirt) to maintain an ideal temperature.
7. We request you print the following information on the specimen container and the lid.
 - Your first and last name
 - Your partner's first and last name
 - Your partner's date of birth (month, day and year)
8. Please do not leave the specimen without confirming the above information with a lab employee.
9. **The male partner must deliver the semen sample to the laboratory himself. Photo Identification will be verified by presentation of a driver's license.**

If, as part of the initial evaluation by your physician, the male partner is diagnosed with abnormal semen parameters, or other causes of infertility, he may be referred to a fertility specialist who specializes in the analysis and treatment of the male partner. Your IVF cycle might be delayed until the evaluation is completed.

Important note: Some men find that the stress of producing a fresh specimen on the day of egg retrieval prevents collection. If this is even a remote possibility, discuss it with your doctor in advance. It is possible to freeze sperm in advance of the IVF procedure.

Post-Egg Retrieval Instructions

Following the egg retrieval, a patient usually spends about an hour in the recovery room before being discharged. Prior arrangements for a ride home are mandatory as the woman must be accompanied by a responsible adult upon discharge and for the first 24 hours after egg retrieval.

The following instructions are important to remember following the egg retrieval:

1. Do not drive a car or return to work for 24 hours.
2. Relax at home for the remainder of the day; activity as tolerated. Do not stay alone for the first 24 hours after receiving anesthesia.
3. Diet and fluid as tolerated, but no alcohol.
4. Bath or showers are permitted after 24 hours.
5. Plain or extra-strength Tylenol® for any discomfort.
6. You will start your progesterone the day after your egg retrieval and take it as prescribed by your physician. Progesterone is continued until the day you receive the results of your blood pregnancy test and you will be instructed at this time as to whether to continue your progesterone or not.
7. A physician is available (on-call 24 hours) for emergencies. If any of the following occur, call the office or the Boston IVF on-call physician at (781) 434-6400:
 - a. Fever over 99.5, orally
 - b. Unusually heavy bleeding
 - c. Persistent pain
 - d. Inability to urinate within 8-10 hours after procedure, with increasing pain.

INSEMINATION OF THE EGGS

The next step of the IVF treatment is to prepare the sperm sample in the laboratory. The sample is analyzed and then a decision is made regarding which is the best insemination technique to use. There are two insemination techniques which are described below:

Standard Insemination- If the sperm sample is adequate then a standard insemination of the eggs can be performed. After the sperm sample has been processed, a mixture of the sperm and eggs is placed in a plastic dish containing a

nutrient culture media and then placed in an incubator in the laboratory to allow fertilization to occur.

Intracytoplasmic sperm injection (ICSI) - ICSI is a laboratory procedure performed to increase the chances of fertilization. The ICSI procedure is a process, whereby, with the aid of a microscope and fine instruments, a single sperm is injected directly into the egg. Indications for ICSI include- a previous IVF cycle with poor fertilization, a previous semen analysis demonstrating significant abnormalities and in situations where surgical aspiration of sperm from the vas deferens or testicle is required. In most cases it is known at the start of the IVF cycle that ICSI will be performed. However, in other cases the sperm sample on the day of the egg retrieval may be unexpectedly inadequate for standard insemination and the ICSI procedure may be performed.

On average, 60-70% of eggs will fertilize following the standard insemination or the ICSI procedure but in some cases none of the eggs fertilize. If fertilization is confirmed, plans are then made for the embryo transfer. In some cases of documented fertilization the embryos stop their development and the embryo transfer is cancelled.

EMBRYO TRANSFER

Fertilized eggs are called *embryos*. Embryos are routinely returned to a woman's uterus 3 days after the eggs have been retrieved. For some patients, the embryos may be grown in culture for an additional 2 or 3 days (day 5 or 6 after egg retrieval). Those embryos are called *blastocysts*. Your doctor will discuss which technique is best for your individual circumstance. A specific time for the embryo transfer will be assigned. Although no special preparation is required, a light breakfast is suggested that morning. On rare occasions, the embryos will not survive the development process and the embryo transfer will be cancelled. We strongly recommend that you leave an accurate contact phone number in case we need to call you on the day of embryo transfer prior to your arrival.

Embryo transfer is a minor procedure (similar to a pap smear) requiring no anesthesia and takes about 5 minutes to perform. Your partner is welcome to be with you at the time of your embryo transfer.

Prior to performing the procedure you will be asked to drink fluids to fill your bladder. To perform the embryo transfer an abdominal ultrasound will be performed. A full bladder allows us to visualize the uterus during the transfer. Next, a speculum is placed into the vagina and the cervix cleansed. Then, a fine plastic catheter is guided through the cervix into the uterus where the embryos are placed. Although usually a painless procedure, some mild cramping may occur.

Post-Embryo Transfer Instructions

The following post-embryo transfer instructions are important to remember:

1. You can resume normal activities, but no high impact activities.
2. Diet and fluids as tolerated.
3. You may shower as usual.
4. Take your progesterone as instructed by your physician.

FREQUENTLY ASKED QUESTIONS ABOUT EMBRYOS

Can you tell if it's a good embryo?

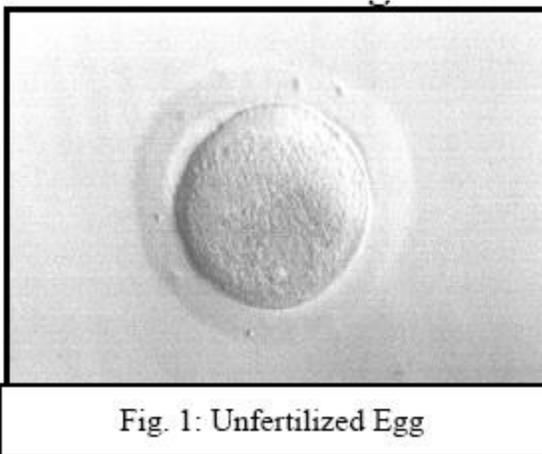
Each patient who comes to the point of an embryo transfer asks this question. The purpose of this section is to explain how we describe embryos at Boston IVF. By reading through this information now, you will be better prepared to discuss your embryos with the doctor when it comes time for your embryo transfer.

Numbers and Letters: How we used to describe embryos

We describe embryos using system of numbers and letters. For example, 6A, 8B, 5C, 3D, etc. Many patients found the descriptions confusing and complex. In order to clarify the grading scheme, we now report cell number and degree of fragmentation.

Numbers and Fragmentation: What does it all mean?

The numbers



An egg is a single cell (Fig. 1). When an egg is fertilized by a single sperm cell it forms an embryo. We can tell that an egg has fertilized when we observe the presence of two pronuclei (Fig. 2). One pronucleus contains the genetic information from the sperm and the other pronucleus contains the genetic information from the egg. This early embryo is still a single cell. Using our numbering system the early embryo at this point can be assigned the number 1.

The one cell embryo then begins the process of cell division (Mitosis). The single cell embryo divides from one cell to two. Using our numbering system the early embryo at this point can be assigned the number 2. At the 2-cell stage, the individual cells begin another round of cell division. Interestingly, the two cells don't divide at exactly the same time. If both cells have divided when the laboratory scientist examines the embryo she/he will see a 4-cell embryo (Fig 3). Using our numbering system



the embryo at this point would be assigned the number 4.



Fig. 3: 2-cell and 4-cell embryos

If only one of the two cells of a 2-cell embryo has divided when the scientist observes it, she/he will see a 3-cell embryo. Using our numbering system the embryo at this point would be assigned the number 3. The embryos cells continue to divide and that is why, on average, we see numbers that range from 1 to 8.

Occasionally several cells of an 8-cell embryo will divide and when observed, and may result in an even greater number of cells.

What is a normal number?

When an embryo is observed 3 days after fertilization we expect to see between 6 and 8 cells. Using our numbering system the embryos at this point would be assigned the numbers 6, 7 or 8. When an embryo has 3 cells or fewer 3 days after fertilization it represents an abnormally slow rate of growth. We do not believe that these embryos can cause a pregnancy. Embryos with 4 or 5 cells are growing at a slightly slower rate but we have seen pregnancies from embryos with 4 or 5 cells 3 days after fertilization.

What is fragmentation of the embryos?

Cell division is not a neat, crisp and clean process. At the cellular level, there is a tremendous amount of activity going on within the cell. Large amounts of cellular matter are being pulled and pushed around in a process orchestrated by the cells' internal machinery. As the cells divide, some of the cellular cytoplasm is commonly ejected in the form of small chips or fragments. We refer to the quantity of chips or fragments as the "degree of fragmentation". We have three descriptive categories for fragmentation: No significant fragmentation, Fragmented and Excessively Fragmented. When an embryo is observed 3 days after fertilization some degree of fragmentation is normal.

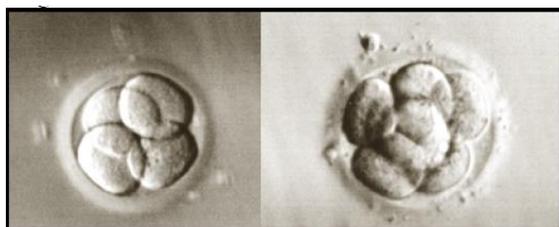


Fig. 4: No significant fragmentation

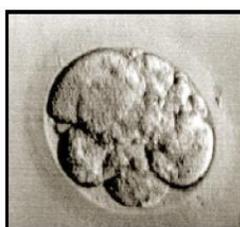


Fig. 5: Fragmented

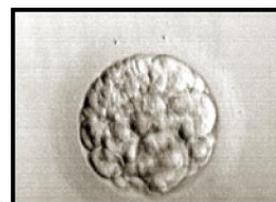


Fig. 7: Excessively
Fragmented

(Fig. 4, 5). An embryo that is excessively fragmented 3 days after fertilization is abnormal (Fig. 7). We do not believe that excessively fragmented embryos can result in a normal pregnancy.

What is a good embryo?

The appearance of an embryo, its cell number and fragmentation, does not tell us whether the embryo will implant and become a baby. If the appearance of the embryo alone predicted success, we would be able to transfer a single embryo, unfortunately however, the cell number and assessment of fragmentation alone do not predict success. That is why we currently need to transfer more than a single embryo during most IVF treatment cycles. Some embryos that have lots of cells and no significant fragmentation may not result in a pregnancy while other embryos with fewer cells and fragmentation may result in a pregnancy.

Are my embryos “HIP”?

Boston IVF scientists have described a method of assessing the implantation potential of individual embryos. Embryos with High Implantation Potential (HIP) typically have 4 cells on Day 2 and 7-8 cells on Day 3 after egg retrieval. In addition, HIP embryos have no significant fragmentation. When one or more developing embryos are HIP we often advise placing fewer total embryos, and under select circumstances a single embryo, back in the uterus.

Can embryos undergo genetic tests to determine if they are normal?

There is a technique known as preimplantation genetic diagnosis (PGD) from which one can learn about the genetic content of individual embryos. This technique is available through Boston IVF for patients with specific medical conditions. PGD can be used to identify embryos affected by inherited genetic diseases that are acquired from the parents. It can also be used to improve live birth rates in certain cases of recurrent pregnancy loss, recurrent failed IVF cycles, and unexplained infertility. It is important to discuss these options with your physician and whether he/she can improve your success in achieving a live birth from IVF. Insurance, in some medically indicated cases, may cover the costs of PGD.

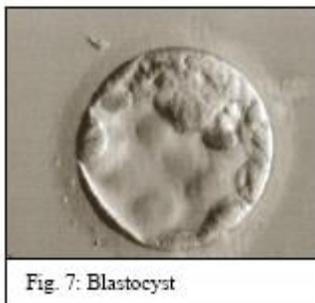
How do you decide how many embryos to transfer?

Your doctor will make a recommendation to you regarding the maximum number of embryos to transfer. Frequently your doctor will leave instructions with the laboratory to put back one embryo fewer if the embryo quality is superb. Patients considered to have a “good prognosis” for a successful live birth from an IVF cycle are advised to undergo an elective single embryo transfer. These patients include women under the age of 35 years who are undergoing their first cycle of IVF, have surplus embryos available for freezing and use in a future “that cycle” and have achieved a live birth from a previous successful IVF cycle.

Evaluating Blastocysts

Blastocysts are embryos with cells that have divided many times. Blastocysts generally reach this stage 5 to 6 days after fertilization and contain 60 to 160 cells. The cells of a blastocyst surround a small fluid pocket (Fig. 7). A small group of cells in the blastocyst called the inner cell mass is the portion that might develop into a baby if the embryo is

capable of reaching its potential. The remaining cells of the blastocyst become the placenta (commonly called “the afterbirth”).



Do you assign numbers and letters to blastocysts?

Blastocysts are more complex structures than are embryos on day 3. The quality of the blastocyst is assessed by noting the size of the fluid pocket and general appearance of the group of inner cells among other things.

Are blastocysts better?

Not necessarily. An embryo that has gotten to the blastocyst stage is a survivor. Therefore, no more than 2 blastocysts are transferred. Unfortunately, many normal embryos might not survive the growth conditions in the laboratory to get to the blastocyst stage. Likewise, growth to the blastocyst stage does not mean that the embryo is genetically capable of becoming a baby. In certain cases, recent advances in the growth and culture of blastocysts have resulted in a higher implantation potential of the transferred blastocysts as compared to the implantation rates of day 3 embryos. This is often the case in younger women who produce numerous embryos of high quality, as assessed on day 2 and 3 of their development.

How do you choose whether or not to try blastocyst transfer?

The decision is made by the patient and her doctor taking into account a number of factors. How many embryos the patient is likely to produce? What about freezing spare embryos? What is the likelihood of a triplet pregnancy or more? It is important to understand that an embryo that makes it to blastocyst was just as likely to produce a pregnancy had it been transferred two days earlier. Therefore, it's the embryo (and the patient), not the fact that an embryo has become a blastocyst, that determines whether pregnancy can occur.

What about freezing embryos?

Extra embryos that are not transferred are observed in the laboratory to see if they develop to a blastocyst. If the blastocyst is confirmed to be of good quality then it can be frozen. It is possible that none of the embryos are of good enough quality to freeze.

EMBRYO FREEZING

Excess good quality embryos from an IVF cycle can be frozen (*cryopreserved*) for use in a later cycle. These embryos may be stored for several years, thawed at a specific time in the menstrual cycle, and transferred to the uterus. To date, over 1750 pregnancies have been established from frozen embryos at Boston IVF (since the early '90's).

Disposition of Frozen Embryos

All couples are asked to carefully consider a variety of options for disposition of stored frozen embryos, select those best for them under a number of unforeseen circumstances and sign a disposition form. The consent form must be signed before embryos can be frozen. This gives Boston IVF specific instructions as to how to dispose of frozen embryos in the event of a divorce or the death of a spouse. Couples who wish to change their decision at any time should do so by making the request in writing to Boston IVF, only if both partners agree to the change. If you agree to freezing extra embryos we suggest that you talk to a financial coordinator about the insurance coverage for freezing and storage of the embryos.

THE PREGNANCY TEST

A blood pregnancy test is performed 14 days after the egg retrieval. This will be scheduled at the time of your transfer. Even if what may be considered a menstrual period occurs, blood pregnancy testing still is recommended as implantation bleeding is often mistaken for the menstrual period.

POST-OPERATIVE APPOINTMENT

We strongly recommend calling your physician's office the day after the procedure, or as soon as possible, to schedule the post-operative appointment. An appointment with your Boston IVF physician should be scheduled for 1 to 2 weeks after the pregnancy test. The post-operative appointment is a critical part of the cycle as it gives the physician and couple an excellent opportunity to review the cycle and discuss possible recommendations for future cycles, including thaw cycles if necessary. If you are pregnant from your IVF cycle, schedule an ultrasound to coincide with your consultation.

Under special circumstances, the post-operative appointment may be done by telephone. Since the doctor will not have all the cycle information until the post-operative visit, we recommend saving your questions until then. Plan to have a one month break from fertility therapy following your pregnancy test, or, in certain circumstances, an approximate 2 week course of oral contraceptives before starting gonadotropins for your next IVF cycle.

FROZEN EMBRYO TRANSFER

A new technique of embryo freezing, known as “vitrification”, has improved the success rates of frozen thawed embryo transfers. Recent data indicates that the transfer of previously vitrified/thawed blastocysts has success rates similar to fresh blastocyst transfers.

To prepare the lining of the uterus estrogen and progesterone will be prescribed. On the morning of the transfer the embryos will be thawed. It is possible that none of the embryos survive the thaw process. The transfer of thawed embryos is the same as that performed in a routine IVF cycle.

The embryo thaw cycle consent form is valid for a year and must be witnessed by one of our clinical staff. The supplemental thaw cycle consent form is valid for 60 days. This **must be** signed by both partners and **notarized** prior to the embryo thaw.

Egg Freezing

Egg freezing is a new option for fertility preservation. Ask your nurse with questions, may require a visit with your MD,

COMMONLY ASKED QUESTIONS REGARDING TREATMENT

Q. Can I swim after my egg retrieval or embryo transfer?

A. Yes, 48 hours after procedure.

Q. Can I use a hot tub, sauna, or Jacuzzi?

A. Yes, after 48 hours but not above 100° Fahrenheit.

Q. Can I get a massage?

A. Yes

Q. Can I have a glass of wine or alcohol during the cycle up until the pregnancy test?

A. No alcohol after procedure.

Q. Can I travel more than 4-6 hours in a car after my embryo transfer? Fly in an airplane?

A. Yes

Q. What length of time should I spend on modified bed rest after an egg retrieval?

A. 24 hours

Q. How much exercise can I do after hCG?

A: None

Q. How much exercise can I do after the embryo transfer?

A. You can resume low impact exercise activities. (Low impact means that you should be able to carry out a conversation while exercising).

Q. Is there a time in my cycle where my partner and I need to abstain from having intercourse?

A. Yes, no intercourse from trigger shot to two days after the retrieval.

Q. Can I get my hair colored or permed?

A. Not in the first trimester.

Q. Can I use Monistat for yeast infections?

A. Yes

Q. Can I have a flu shot during treatment or in pregnancy?

A. All women who are trying to conceive or whom are pregnant should receive a flu shot. (Only the flu shot not the nasal spray).

Q. What medications can I take after my transfer?

A.

For Pain	Tylenol® or Acetaminophen only
For Heartburn	Mylanta ®, Maalox ®, Rolaids ®, Tums ®, Riopan ®, or Riopan plus ®
For Constipation	Colace ® or Metamucil ®
For Upper Respiratory Symptoms	Benadryl ®, Robitussin ® (Guaifenesin), Tylenol cold, Sudafed ® (unless you have high blood pressure or are being monitored for preeclampsia).

*Any other medication questions please call your nurse.

Risks of Treatment

Ovarian Hyperstimulation

Gonadotropins can occasionally cause hyperstimulation of the ovaries. This means that the ovaries are especially sensitive to the medication and enlarge with temporary cysts. To decrease the risk, your physician prescribes the lowest possible dose of medication. When taking gonadotropins, your response is monitored with ultrasound and estradiol blood tests.

Even with careful monitoring, occasionally some women do develop hyperstimulation. Hyperstimulation usually occurs 5 or more days after ovulation or after the hCG injection. Usually, this problem will reverse itself without treatment within in 2-3 weeks. Please check for the following signs and symptoms, which may indicate hyperstimulation. If you develop any of the following symptoms, please call your physician as soon as possible.

Weight Gain: A weight gain of two pounds or more for two days in a row may be a warning sign. Please weigh yourself daily and report any sudden or rapid weight gain.

Abdominal Pain: While mild bloating and cramping may be normal, watch for excessive bloating, or unusual tenderness or pain in your abdomen. Sometimes abdominal pain is accompanied by nausea, vomiting and/or diarrhea.

Urine Output: Please let us know right away if you notice any obvious change in urine output, either an increase or decrease. At the same time, check for signs of bladder infection (burning, painful or frequent urination).

Shortness of Breath: If you have any difficulty breathing, either at rest or during activity, please report this at once.

If you notice any of the above symptoms, call your physician as soon as possible. A simple physical exam is sometimes all that is needed to check for hyperstimulation. In some cases, a pelvic ultrasound and/or blood tests are also necessary.

If hyperstimulation is mild to moderate, you will be asked to return to the office within the week for another exam and possibly an ultrasound. You will be asked to continue to check your weight every morning to be sure you are drinking and urinating properly. If hyperstimulation is severe, your doctor may advise you to have an outpatient procedure to drain some of the excess fluid that can collect inside the abdominal cavity that causes bloating and pain. This procedure may allow the hyperstimulation to resolve quicker and usually improves your symptoms. In addition to the above advice, you will be placed on bed rest. In rare cases, hospitalization is necessary to more accurately monitor weight changes and ovarian status. There is a remote chance of severe illness, such as bleeding from the ovary, blood clots, kidney failure, etc. With current experience with these medications such effects are extremely remote. In the presence of hyperstimulation, it is important to avoid strenuous activities, either work or sports related. In addition, heavy housework that involves pushing or lifting (e.g., vacuuming) should be avoided. Intercourse is not advised in cases of moderate to severe ovarian hyperstimulation. Pregnancy can occur (possibly more readily) in the presence of hyperstimulation. Therefore, it is important to have a blood test for pregnancy if ordered by your physician.

Multiple Pregnancy

The advent of modern fertility treatments has led to a substantial increase in the frequency of twins, triplets, quadruplets, quintuplets and even higher order multiples as shown by the birth of septuplets in Iowa in 1997. Multi-fetal pregnancy refers to a pregnancy in which two or more fetuses are present in the womb.

In the general population, multi-fetal pregnancies occur in approximately 1 to 2 percent of all pregnancies. However, with the use of fertility drugs such as clomiphene citrate or gonadotropins (FSH) and high-tech procedures such as in vitro fertilization (IVF), multiple gestations are much more common. The vast majority of these pregnancies are twins, but triplets, quadruplets and higher numbers can occur. Triplets and higher order multi-fetal pregnancies occur in 3% to 4% of couples undergoing IVF, and in 7% to 8% of patients undergoing ovulation induction with injectable FSH preparations.

Fetal and Maternal Risks

Fetal risks of multiple gestations include an increased chance of miscarriage, birth defects, premature birth and the mental and/or physical problems that can result from a premature delivery. The average length of pregnancy is 40 weeks for a single gestation; 36 weeks for twins; 33 weeks for triplets; and 29 weeks for quadruplets.

Triplet pregnancies have a perinatal mortality rate up to 12 times higher than that of singletons and 10% of triplets die at or about the time of birth. Quadruplet pregnancies are even more risky - women with quadruplet and higher order gestations deliver prematurely and of those that reach 24 weeks' gestation, approximately 25% of babies will die at or about the time of birth. For those babies that do survive they are far more likely to be handicapped by cerebral palsy, kidney failure, blindness and mental retardation. Maternal risks due to multiple gestations include premature labor, premature delivery, pregnancy-induced high blood pressure or pre-eclampsia (toxemia), diabetes and vaginal or uterine hemorrhage.

Reasons for Increased Risks

The uterus can normally increase its blood supply to nourish about 10 pounds worth of baby or babies. The uterus usually accommodates twins well but twin pregnancy is still associated with greater risk to the mother and babies than is a singleton pregnancy.

However, more than two babies can be problematic. As stated above, studies and surveys indicate that, on average, triplets are born seven weeks early, weighing 3.5 to 4 pounds. Quadruplets tend to be born 11 weeks early, weighing 2.8 to 3.5 pounds. Their prematurity is almost certain even though most of their mothers rest in bed for months, wear home monitors to count contractions and take drugs to ward off early labor.

Multi-fetal Pregnancy Reduction

Multi-fetal pregnancy reduction (MFPR) is a technique that reduces the number of fetuses in an effort to increase the likelihood that the pregnancy will continue safely. Consequently, the risks to the mother and remaining fetuses are reduced. The first multi-fetal pregnancy reductions were performed between 1986 and 1988, and since then, thousands of patients have had the procedure performed successfully.

The procedure is more likely to be performed when there are three or more fetuses present. The number of fetuses is usually reduced to two although in some circumstances they may be reduced to one. Because twins generally do better than higher order multiples, reduction in these cases is more individually determined and may be considered.

Timing and Technique for MFPR

Multi-fetal pregnancy reduction is usually performed between nine and twelve weeks gestation but it has been performed as late as 24 weeks gestation. The procedure is most successful when performed early in pregnancy on an outpatient basis. Anesthesia is usually administered and includes a mild sedative along with local skin infiltration.

According to some studies, the optimal number of fetuses following the MFPR procedure appears to be twins, since the outcome with twin pregnancies is generally good, and appears to be similar to the outcome for pregnancies reduced to singletons.

The risk of an induced miscarriage related to MFPR is 8% to 9%. Although this is a significant risk and must be considered before undertaking the procedure, the risk is not higher than the 10% fetal loss rate found in twin gestations following assisted reproductive technology. Maternal infection rarely occurs and injury to a surviving (non-reduced) fetus is considered to be highly unlikely.

Counseling

The best time to consider MFPR is prior to starting treatment. Dealing with the decision of whether or not to undergo multi-fetal pregnancy reduction can be an emotionally traumatic experience. Couples who have invested a great deal of time, energy and money in pursuing pregnancy are often unprepared to make this decision. It is usually helpful for couples considering multi-fetal reduction to undergo professional counseling prior to undergoing the procedure.

Both partners need to be comfortable with their decision and may need emotional support prior to and immediately following the procedure. The decision to proceed with MFPR is made with the intent to give a better chance of survival for the remaining babies from high order multiple gestations and reduce the likelihood of significant mortality and morbidity associated with these pregnancies.

Conclusion

MFPR has become an accepted procedure that can be performed safely with technical success. In select patients with higher order gestations, it provides an intervention that increases the chance of achieving the desired outcome (taking home a healthy newborn) while minimizing the associated risks of multi-fetal pregnancy.

Birth Defects

Most infants who have been born following in vitro fertilization are normal. The rate of congenital abnormalities (birth defects) in babies conceived naturally is 2-3%. Some published studies have reported that there is an increased risk of birth defects in babies conceived following IVF. It is important to be aware that genetic abnormalities, structural abnormalities, mental retardation and other abnormalities may occur in babies conceived following IVF, as well as, those conceived naturally.

Ovarian Cancer

In the general population, every woman has a 1 in 70 chance of developing ovarian cancer during her lifetime. Studies have shown that infertile women have a higher chance of developing ovarian cancer than fertile women. Controversial data exists that associates the use of ovulation induction drugs (e.g., clomiphene citrate, gonadotropins) with an increased risk of ovarian cancer. However, presently a cause and effect relationship has not been clearly established.

TELEPHONE CONTACT DURING TREATMENT

Patients undergoing daily injections of gonadotropins will receive a call between 2:00 to 4:00 p.m. with instructions as to the dose of medication required that evening. Please make arrangements to be available for that phone call. ***If you have not heard from the office by 4:00 p.m., please be certain to contact the office.*** The dose of gonadotropins may be reduced, increased or maintained at the same level. Please be sure to have at least a two day supply of gonadotropins available should you be told to take that dose or a slightly increased dose. This arrangement avoids you having to rush to the pharmacy late in the afternoon for your evening dose of gonadotropins.

HOW TO GET STARTED

QUICK PRE-TREATMENT CHECKLIST:

1. Check with our financial coordinators to obtain the necessary insurance authorization for treatment. This can take several weeks in some cases. Further information about insurance authorization is available on line at www.bostonivf.com. Click on “**For Patients**” tab on the top right hand side of the screen. Log in with the user name “**bostonivf**” and password “**patient**”. Download our booklet entitled "Guide to Infertility Insurance Coverage"
2. Download the "cycle calendar" that matches your treatment as well as the treatment guide entitled "IVF Treatment Guide" they are available on line at www.bostonivf.com. Click on patient resources on the top right hand side. Then log in with the user name “**bostonivf**” and password “**patient**”. Click on "IVF Documents" and select your cycle calendar and treatment guide.
3. **Orientation & Injection Teaching**
Please go to www.bostonivf.com scroll down to the bottom of the website and you will see on the right had side the link for **Village Pharmacy** and **Freedom pharmacy**. There is no passcode needed to access the websites, just click right in, to watch the videos on your specific medications
4. Call your nurse for prescriptions for **ALL** medications that you will use during your treatment cycle.
5. Call patient educational services at 781-434-6524, to arrange for either a telephone orientation or in-person injection lesson prior to the start of treatment.
6. Treatment generally can begin after you have met all prerequisites and insurance authorization has been obtained. Please check that you have received all of the medications and supplies that you will need during the treatment cycle 1-2 weeks prior to your anticipated menses.

7. You should call your clinical assistant on the first day of your menstrual period to start a cycle. If your period starts after 5 p.m., then you should call the following morning.
8. Please be sure to complete "One Medical Passport" prior to your egg retrieval. The instruction sheet on how to complete this can be obtained on our website www.bostonivf.com. Click the "For Patients" tab on the top right hand side of the screen. Log in with the user name "bostonivf" and password "patient" then click the "IVF Documents" tab---the document you should print is called "One Medical Passport".

HOLIDAYS OBSERVED AT BOSTON IVF

The following are holidays observed by Boston IVF. Please call the office on the next day if you need to schedule an appointment with a secretary. However, be aware that the Boston IVF-Waltham office is open in the morning on holidays for IUI appointments only.

New Year's Day	Labor Day
President's Day	Columbus Day
Patriots Day	Thanksgiving Day
Memorial Day	Day after Thanksgiving Day
Independence Day	Christmas Day

DIRECTIONS

Please visit our website for directions to the Boston IVF centers

WALTHAM HOTEL LISTING

Holiday Inn Express	Embassy Suites
385 Winter Street	550 Winter St
Waltham, MA	Waltham, MA
(866) 335-6208	(781) 890-6767

THE DOCTOR ON CALL

For your safety, there is a Boston IVF doctor on call 24 hours a day for medical emergencies only. Please address all routine questions including test results and cycle starts with the office staff during business hours (9 am to 5 pm) Mon – Fri. Weekends and holidays (9-am to 3pm).

***If you receive your period, (cycle day one, and the first day of a full flow bleed) after 5pm, call to speak to a nurse the following day. There is no urgency with any treatment plan to start that night. ***