

## RMU CLINIC INFORMATION

### *Welcome to the Reproductive Medicine Unit (RMU)*

The RMU offers a full range of male and female fertility investigations and treatments.

We are the largest provider of NHS fertility treatments in the United Kingdom. Self-funding treatments are also available. On average, the unit performs approximately 1,000 treatments per year.

#### Unit Opening Hours:

- Monday – Friday                      8.00am – 5.00pm
- Saturday                                8.00am – 1.30pm
- Sunday                                    Closed

At your first appointment on the unit, we will discuss your specific treatment in detail, check the necessary paperwork e.g. consent forms, and discuss the role of the H.F.E.A.

We are licensed by the Human Fertilisation and Embryology Authority (H.F.E.A.) to perform:

- In vitro Fertilisation (I.V.F.)
- Intracytoplasmic Sperm Injection (I.C.S.I.)
- Percutaneous Epididymal Sperm Aspiration / Testicular Sperm Extraction (PESA / TESE)
- Cryopreservation
- Frozen Embryo Replacements
- Assisted Hatching
- Transport In vitro Fertilisation
- Ovum Donation
- Donor Insemination

#### The Unit Team

- We have a team of staff including Consultant Gynaecologists, a Scientific Director, Consultant Andrologist, Research Fellows, Nursing Staff, Embryologists, Seminologists, Counsellors and Administrative Staff.
- We are closely affiliated to the LINK Support Group, an extremely active patient led group.

## WHAT WILL HAPPEN AND WHEN

After attending your patient information evening, your screening investigations will be performed. For the woman this is usually a blood test when you are having a period; for the man a sperm test.

You will then attend a clinic appointment on the Reproductive Medicine Unit to discuss your results. If your blood test and sperm test results are satisfactory and if all of your consent forms are returned then the nursing staff can plan your treatment cycle dates.

If any problems are detected with your blood or sperm tests then further tests may be necessary.

Providing that your results and consent forms do not need any further action then your treatment may begin 1-2 months after your clinic appointment. (see IVF Flow-Chart)

If a treatment cycle is unsuccessful and you are able to continue your treatment, then we advise that you wait for 2 normal periods before you try again. The unit staff will discuss your options with you as appropriate.

### Other information

When you attend the unit, particularly for scans, egg collections and embryo transfer, we ask that you do not use perfume/after-shave or strong smelling deodorants that day as embryos are sensitive to air borne smells.

Due to the number of treatment cycles that we perform, we have scan sessions every morning, Monday-Friday. We operate an appointment system for this, however, short delays are sometimes unavoidable.

There is a 'Suggestion Box' located in the waiting room. If you have any comments/suggestions then please let us know.

Please note that the hospital Pharmacy department is closed Saturdays and Sundays.

## THE LINK SUPPORT GROUP

The LINK Support Group holds a meeting the 2<sup>nd</sup> Wednesday of every month between 7.30-9.00pm in the Training Room on the ground floor of the Women's Hospital.

Each meeting usually has an organised speaker to discuss various aspects of treatment followed by time to have a chat with others over a cup of tea or coffee. All patients are welcome.

If you would like to talk to someone about the group, please feel free to phone either Chris Malone on 0151 702 4124 or Lorrie Hudson on 0151 702 4075.

*May the staff of the unit take this opportunity to wish you every success with your treatment.*



## Support Group

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**A Self Help Group Linking Couples Undergoing Fertility Treatment for Mutual Support and To Share Information**

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**Link Support Group** is run by patients for patients. Wherever you're up to, waiting on a list, undergoing treatment, or just considering what to do next, come along to one of our regular meetings.

The isolation that you may be feeling because of your infertility is common. Infertility is a very personal condition which you may find difficult to discuss with those around you. The Group helps by allowing you to meet other people in the same situation. Remember, you are not alone!

Our meetings are friendly and informal. We meet to talk with each other and we invite speakers who can give us more information about infertility. This could be one of the consultants or staff from a local hospital, who may speak about IVF, DI or male infertility. We also invite speakers to talk about alternatives to treatment that we may be considering, such as adoption.

We meet on the second Wednesday of every month from 7.30pm at The Liverpool Women's Hospital in the Training Room on the Ground floor. If you need any further information, please call us on the telephone number below or ask one of the staff on the Unit.

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**Link Support Group \* Room 0175 \* Ground Floor\* Liverpool Women's Hospital \* Crown Street\* Liverpool L8 7SS \* Telephone: 0151 702 4075/4079**

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If you wish to be added to our mailing list to receive our regular newsletter, please fill out the following information and return this slip to the address below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

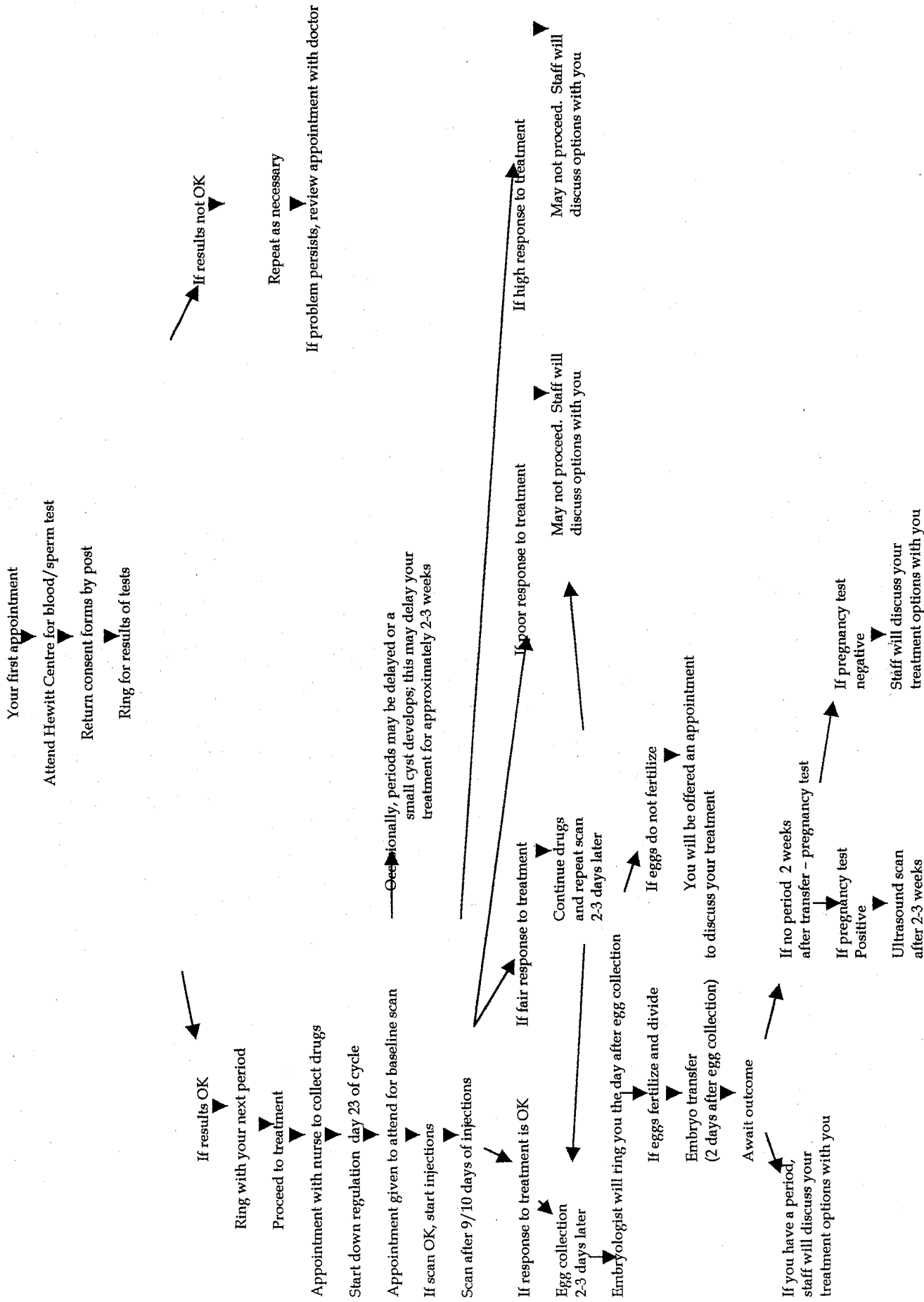
Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

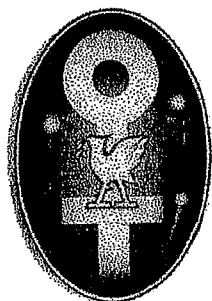
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**Link Support Group \* Room 0175 \* Ground Floor \* Liverpool Women's Hospital\* Crown Street\* Liverpool L8 7SS \* 0151 702 4075/4075**

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*The Link Support Group is available to help at any stage of your treatment.*



# LIVERPOOL WOMEN'S HOSPITAL

## THE HEWITT CENTRE FOR REPRODUCTIVE MEDICINE

IVF treatments and results for the twelve month period ending 31 March 2003:

Clinical Pregnancy Rates		
	Below 38	All ages
Treatment cycles started (IVF & ICSI)	19.8% (144/729)	19.1% (178/931)
Egg collection	20.0% (144/722)	19.3% (178/923)
Embryo transfer	23.1% (144/624)	22.3% (178/800)
IVF only (per embryo transfer)	22.3% (54/242)	22.2% (70/316)
ICSI only (per embryo transfer)	23.6% (90/382)	22.3% (108/484)
Frozen embryo replacements (per embryo transfer)	15.1% (36/239)	14.5% (43/296)

Other results for all IVF treatments (incl. IVF)	
Patients treated	981
Singleton births/ongoing pregnancies	161
Twin births/ongoing pregnancies	59
Triplet births/ongoing pregnancies	1
Cycles where 2 embryos transferred	917
Cycles where 3 embryos transferred	53
Abandoned treatment cycles	55
Treatments with donated eggs or embryos	
Cycles with donated eggs	35
Cycles with donated embryos	3
Number of live births/ ongoing pregnancies	9

IVF treatments and results for the preceding twelve month period ending 31 March 2002:

	Clinical pregnancy rates		Live birth rates	
	Below 38	All ages	Below 38	All ages
Treatment cycles started (IVF & ICSI)	16.3% (125/767)	14.4% (141/977)	15.3% (117/767)	13.3% (130/977)
Egg collection	17.6% (125/709)	16.0% (141/883)	16.5% (117/709)	14.7% (130/883)
Embryo transfer	20.2% (125/619)	18.5% (141/762)	18.9% (117/619)	17.1% (130/762)
IVF only (per embryo transfer)	21.2% (54/255)	17.3% (59/312)	19.2% (49/255)	16.7% (52/312)
ICSI only (per embryo transfer)	19.5% (71/364)	18.2% (82/450)	18.7% (68/364)	17.3% (78/450)
Frozen embryo replacements (per embryo transfer)	11.0% (30/273)	11.6% (37/320)	9.5% (25/273)	9.4% (29/320)

## Healthy Living –Preparing for Pregnancy.

Most people would benefit from improving their health, particularly couples who are trying to have a baby. A healthy lifestyle can improve your fertility and can also increase your chances of successful treatment.

How can I improve my health and fitness before my treatment?

This is a commonly asked question so we have put together some advice for **both men and women** to help you improve your health and fitness.

### 1. Stop Smoking



- The most important thing you can do if you smoke is - **give up!**
- We know this is easier said than done but many research studies have shown the harmful effects of smoking on sperm quality, egg quality and implantation rates for fertilised eggs.
- Smoking affects many aspects of your general health such as increased risk of cancer, heart disease, lung disease and premature ageing.
- Passive smoking can affect partners and other people.
- Smoking is an expensive way to damage your health!

If you need help to give up smoking try the following for support:

- 'Quitline' on 0800 002200.
- Your GP or Practice Nurse.
- The nursing staff of the Reproductive Medicine Unit on 0151-702-4123/4249.
- Liverpool Women's Hospital's Smoking Cessation Advisor on 0151 707 1555
- 'Fag Ends' on 0151 261 0202.

### 2. Achieve a Healthy Body Weight



- A healthy weight for height is referred to as a healthy Body Mass Index (BMI).
- You can check your BMI using the enclosed chart.
- It is important that you are **both** as near to your ideal BMI as possible.
- Being over weight **or** under weight can cause general health problems but can also affect your fertility.
- Aim for a BMI of between 21 and 30 (ideally 21 to 25).

If you need help achieving your ideal weight then contact your GP for a referral to a dietitian, or contact the nursing staff on RMU on 0151-702 4123/4249.

**NB:** Healthy weight loss is a slow gradual process. As you wait for your treatment – use this time wisely. A loss of 1-2 lb. (0.5-1.0 kg) per week is adequate.

### 3. Take Regular Exercise



- Regular exercise improves physical fitness, helps you to lose weight and decreases stress levels.
- Aim for some form of 'Aerobic exercise' three times per week, i.e. any activity that increases your heart rate and breathing, such as brisk walking, jogging, swimming, or sporting activities like football, tennis or squash.
- You do not need to join an expensive club or buy lots of equipment to get enough exercise. A brisk twenty-minute walk two to three times per week can be beneficial.
- Using stairs instead of using lifts/escalators and walking to the shops can all make a difference and will improve your fitness.

### 4. Reduce Alcohol Intake



- Excessive alcohol reduces fertility & damages sperm.
- For general health purposes the safe limits are up to 21 units per week for men and up to 14 units for women.
- However, men **and** women trying for a baby should limit alcohol intake to no more than 5 units per week.
- It is better to have one to two units occasionally rather than saving them all up for one night!

### 5. Drink plenty of water



- Our bodies need between 8 and 10 cups of fluid per day.
- Some studies suggest that excessive caffeine can reduce your fertility – Tea, Coffee, Cola and 'energy' drinks e.g. Red Bull are particularly high in caffeine – try caffeine free alternatives or drink water or squash.
- When you are having your treatment cycles we will suggest that you avoid caffeine altogether.

## 6. Follow a Healthy Eating Plan

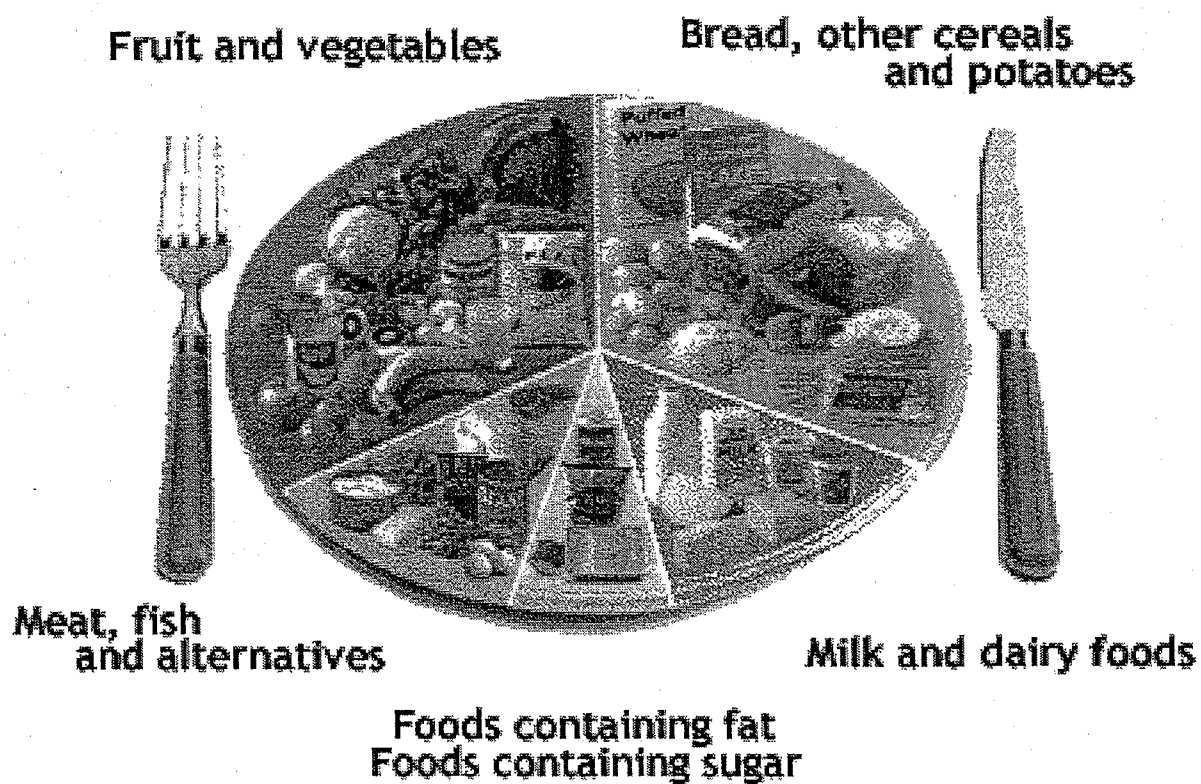


- Eat regular meals
- Eat similar foods to the rest of the family
- Enjoy your food
- Eat a wide variety of different foods

Why is healthy eating important?

- It helps you to achieve and maintain a healthy body weight.
- It ensures your body has sufficient vitamins and minerals – essential for men & women trying to conceive.
- It ensures your body has enough energy for all your daily activities.

The picture below shows the proportions of food from each food group, as we should eat them each day:



*Reproduced by kind permission of the Food Standards Agency.*

Here are some tips to help you achieve the recommended proportions:

### **Eat More Fruit and Vegetables**

- Fruit and vegetables are excellent sources of vitamins and minerals
- Aim for at least five portions of fruit and vegetables a day
- If you are trying to lose weight fruit makes an excellent snack or dessert
- Choose fresh, frozen or tinned (avoid fruit tinned in syrup)

NB A portion =

- 1 apple, pear, banana
- 1 slice of melon or pineapple
- 2 plums or satsumas
- 1 cup of strawberries/raspberries
- 2 tablespoonfuls of vegetables (raw, cooked, frozen or canned)
- 1 dessert bowl of salad

### **Fill up on starchy foods**

- This includes bread, cereals and potatoes
- Try wholegrain varieties where possible e.g. wholemeal bread, bran flakes etc.
- These are higher in vitamins and minerals and also help to fill you up -so you are less tempted to snack between meals

### **Meat Fish and Alternatives**

- These foods are important for protein and iron as well as other nutrients
- Vegetarians should include pulses, beans or nuts to replace meat or fish
- Take care with fat content of meat or fish- especially if trying to reduce your weight

### **Dairy Products**

- Milk, cheese and yoghurt are important for calcium, protein and other nutrients
- Choose low fat varieties as much as possible, for example, skimmed milk, cottage cheese or low fat yoghurt (especially if trying to lose weight).
- Low fat varieties have as much calcium as the regular versions

### **Occasional Foods**

- Many snack and convenience foods contain lots of fat and sugar e.g. sweets, chocolate, biscuits, burgers, cakes, crisps and pastries.
- They are low in vitamins and minerals and high in calories, so should only be eaten occasionally.
- Added fats e.g. butter, oils and margarine should be used sparingly.

### **Take Folic Acid**

- It is strongly recommended that women take 400µg of folic acid per day, 3 months before pregnancy and until 12 weeks after you conceive.
- Good dietary sources of folic acid include fortified breakfast cereals, fortified bread, sprouts, spinach, Bovril and oranges.

## Do I need to take any other supplements?

Please seek advice from a pharmacist before taking any other vitamin supplements or herbal remedies.

### **Want to know more?**

- Ask your GP to refer you to a State Registered Dietitian.
- Contact the 'Eating for Pregnancy' Helpline on: (0114) 242 4084.

## **7. Cope with Stress**



We know from couples undergoing infertility treatment that their experience can be an extremely stressful one. This is understandable, especially if a couple believe that their future happiness depends upon a successful treatment outcome. Stress in such a situation is unavoidable. However, it is not stress itself that causes problems but the way in which an individual responds to it.

Without positive ways of dealing with stress a couple undergoing infertility treatment may experience some very negative symptoms such as:

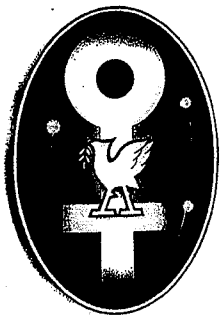
- insomnia,
- fatigue – constant lack of energy,
- anxiety,
- inability to concentrate for long,
- mood swings,
- depression.

Staff at the unit want to help couples avoid the distress such symptoms bring about. For this reason we recommend that you give some thought now as to the coping mechanisms you currently employ to deal with stress. Are they positive and likely to get you through treatment in good shape? Or, are they negative and therefore likely to make the situation worse?

Here are some ways of coping positively with stress that some couples have found helpful:

- yoga,
- physical exercise – swimming, running etc.
- learning how to relax – using tapes, books, videos,
- stress management courses – night school, information from GPs, libraries etc.
- support – building your own network using friends, family, counsellors (addresses from your GP)

We want you to feel able to give treatment its best chance of success. Using positive coping mechanisms to deal with stress may help you to do it.



Liverpool  
Women's  
Hospital

## REPRODUCTIVE MEDICINE UNIT

**TO BE RETURNED TO R.M.U.**

Liverpool Women's Hospital  
Crown Street  
Liverpool L8 7SS  
Tel: 0151 708 9988  
Fax: 0151 702 4028

Your ref:  
Our ref:  
If telephoning please ask for:

.....  
Direct Line: 0151 702 4121  
Direct Fax: 0151 702 4137

### CONSENT FOR FREEZING OF EMBRYOS

We understand that from a cycle of treatment we may produce embryos which would be of suitable quality for freezing.

We understand and accept that the suitability of embryos for freezing is the decision of the embryologist.

We understand and accept that the Unit cannot accept responsibility if in the case of an accident/equipment failure stored embryos are lost or damaged making impossible their future use for embryo transfer.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name (*in block letters*) \_\_\_\_\_

Signature: \_\_\_\_\_

Name (*in block letters*) \_\_\_\_\_

Signature: \_\_\_\_\_ for the unit

Name (*in block letters*) \_\_\_\_\_

### **Important Information**

**When you start a cycle of treatment with us we advise that you use barrier methods of contraception (eg. condoms) until your treatment is complete. Although our aim is to help you achieve a pregnancy we strongly advise that you do not get pregnant when you are taking Buserelin nasal spray or injections. This is because of a possible increase in miscarriage rates.**

**If you have any questions about this please ask the staff when you are next in clinic or phone the nursing staff on 0151-702-4123 or 702-4249.**

**Thank-you**

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# REPRODUCTIVE MEDICINE UNIT

## INFORMATION FOR PATIENTS CONCERNING THE USE AND STORAGE OF EGGS, SPERM AND EMBRYOS

Please use this information to help you complete the white Human Fertilisation and Embryology Authority (HFEA) consent forms about using and storing eggs, sperm and embryos. It may help you to read this information and the consent forms together, section by section. There are two consent forms, one about eggs and embryos to be filled in by the female partner and one about sperm and embryos to be filled in by the male partner. The two forms are very similar, and this information sheet covers some general points and also goes through each section of the forms in turn.

You are being asked to make these decisions about use and storage at a time when you might be feeling stressed, or apprehensive about the treatment ahead and your chances of success. This is why we want you to take this information home and think about things in your own time. If there is anything which is not clear to you, or if you want any additional information, please ask us.

### **Section 1. Use of eggs, sperm and embryos**

This section asks you to think about your eggs and sperm and how you would like them to be used, and then to consider what should happen to any embryos which may develop from them.

#### **a. Eggs and sperm**

##### *a.i. In treating any partner of mine.*

This section of the forms refers to the use of your own eggs and sperm to produce embryos for your own treatment. Both partners need to agree to this for treatment to go ahead.

##### *a.ii. In treating others*

This section does not apply to treatment in our Unit at present. We will not be asking you to donate either eggs or sperm from your treatment cycles to other patients, so you may tick 'no' or write in 'not applicable'.

##### *a.iii. In any project of research*

This section is asking you to consider donating eggs or sperm to research projects in the Unit. Donating eggs and sperm will not lower your own chances of success.

One or two eggs may be donated to research on the day of egg collection, but they will only be used if we are sure that there are enough for your own treatment. You may tick 'yes' for research, and then state any conditions as to use. For example, you may only want to donate one or two eggs to research if we collect more than a certain number. You can write this in the space provided on the form.

As there are normally so many millions of sperm in each sample, there are usually more than enough to mix with all the eggs collected, no matter how many. Please tick 'yes' in this section if you would like to donate any sperm left over to research. This can be useful even if there is a possible sperm problem, as we are trying to develop better methods of assessing sperm function and treating 'male factor' infertility.

None of the decisions you make about research will affect the way you are treated. Also, you may change your mind at any time before the eggs, sperm or embryos are actually used.

b. Embryos

*b.i. In treatment of myself together with a named partner*

This section refers to the embryos which will be used for your own embryo transfer. We need to have permission from both partners in order to replace the embryos and complete your treatment cycle.

*b.ii. In treating others*

This section does not apply to this Unit at present and you will not be asked to donate embryos to any other patient. You may tick 'no' or write in 'not applicable'.

*b.iii. In any project of research*

We are allowed by law (HFEA Act 1991) to replace a maximum of three embryos in any treatment cycle, and the embryologist will choose the three which seem to be developing most successfully. This means that sometimes there will be embryos left over, and you may choose to donate some or all of these embryos to research. This may be your first choice, or you may prefer to have your embryos frozen, and only used for research if they are not suitable for the freezing procedure. Also, in IVF treatment a small number (about 2-3%) of eggs may fertilise abnormally and cannot be used for treatment, and you may wish to donate these to research.

In order to use embryos for research we need consent from both partners, and you may state any conditions as to their use, for example if they are abnormal or unsuitable for freezing. These conditions may be written in the space on the form.

If, for any reason, you do not want any of your embryos to be used for research you may tick 'no', and this will not affect your treatment in any way.

Research is necessary to develop new treatments and improve success rates. Embryo transfer does not always lead to a pregnancy and we need to find out why some embryos produce a pregnancy and others, which look just as good, do not. We have a licence from the HFEA to carry out projects designed to provide this information, and also to improve IVF culture conditions so that more successful embryos are produced. Complete records of all investigations, results and consent forms are kept for the HFEA to check.

### **Section 11. Storage**

This section of the forms deals with the storage of sperm and embryos, but not eggs. This is because it is not yet possible to freeze and store human eggs successfully.

a.i. Sperm will not usually be stored as part of your treatment. This is because treatment is more successful if a fresh sample is obtained each time. Very occasionally, sperm may need to be banked as part of a programme of treatment for certain male factor problems, and if this is necessary it will be dealt with separately by our consultant Andrologist. However, if you have decided to donate sperm to research we may sometimes need to freeze and thaw sperm in one of our projects so it would be helpful if you could also agree to allow us to store sperm for a time, perhaps one or two years. Otherwise, you may tick 'no' or write in 'not applicable'.

a.ii. Embryos may be frozen and stored for transfer at a later date. If you would like your spare embryos to be frozen, the embryologist will freeze all those which are suitable. If you would like to donate any unsuitable embryos to research you may write this in section b.iii. Embryos may be stored for a maximum of five years by law, but you may choose a shorter time if you wish.

- b. If you choose to have embryos frozen we need to know what should happen to them in the unfortunate event of any accident.
- i. They may be allowed to perish.
  - ii. They may be used for purposes given in section 1.b. This means, for example, that if something happens to one partner the embryos may be used for treatment of the other, or they may be used for research if you have already agreed to this.
  - iii. Continue in storage for other purposes. For example, you may not have agreed to research previously but would be prepared to consider it in this situation. There is space on the form for you to write in anything you wish to specify.

These decisions are quite complex and very personal, and the Unit staff, including the counsellor, are available to help you at any time.

[illegible][illegible][illegible]

- iii. in any project of research YES ☐ NO ☐

[illegible]

- iii. in any project of research YES ☐ NO ☐

Signature: \_\_\_\_\_ Date: 

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\*Centres are allowed to store sperm for longer periods for limited uses only.

- If less than five years or some other period please state the number of years: YEARS

\*This does not apply to donors.

- YES ☐ NO ☐ YES ☐ NO ☐

- DAY MONTH YEAR

**N.B. Do not sign this form unless you have received information about these matters and have been offered counselling. You may vary the terms of this consent or withdraw this consent at any time except in relation to eggs or embryos which have already been used. Please insert numbers or tick boxes as appropriate.**

**Full Name (block capitals):**

[illegible]

Any other name by which you have been known:

[illegible]

a. I hereby consent to the use of my eggs for the following purposes:

- i. in my own treatment YES ☐ NO ☐
- ii. in treating others YES ☐ NO ☐
- iii. in any project of research YES ☐ NO ☐

Please state any particular conditions as to use:

**b. I hereby consent to my egg(s) being fertilised *in vitro* to develop embryo(s) and to the use of those embryo(s) for the following purposes:**

- i. in the treatment of myself YES ☐ NO ☐ or  
in the treatment of myself YES ☐ NO ☐  
with a named partner

Full name of partner:

[illegible]

- ii. in treating others YES ☐ NO ☐
- iii. in any project of research YES ☐ NO ☐

Please state any other conditions as to use (eg on the use of particular embryos):

**Signature:**

Date:

DAY	MONTH	YEAR

**a. I hereby consent to the storage of my eggs:**

**Storage period in years Maximum (10 years)\***

YES | | NO | |

If less please state YEARS \_\_\_\_\_

\* Centres are allowed to store eggs for longer periods for limited uses only.

b. I hereby consent to the storage of embryo(s) developed *in vitro* from my egg(s):

**Storage period in years:**

Five years YES | NO | Ten years YES | NO | More than 10 years YES | NO |

If less than five years or some other period please state the number of years: YEARS |

I understand that consent to storage of more than five years must be accompanied by a completed HFEA(96)8 form which has been signed by a registered medical practitioner.\*\*

**\*\*** This does not apply to donors

c. If I die or become mentally incapacitated my eggs or the embryo(s) developed *in vitro* from my egg(s) should:

EGGS	EMBRYOS
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- i. be allowed to perish YES ☐ NO ☐ YES ☐ NO ☐
- ii. continue in storage for the purposes given in 1a (for eggs) and 1b (for embryos) above\*\*\* YES ☐ NO ☐ YES ☐ NO ☐
- \*\*\* This is only valid for 1a.ii and 1b.ii and 1b.iii
- iii. continue in storage for other purposes YES ☐ NO ☐ YES ☐ NO ☐  
(please specify below)

\*\*\* This is only valid for Ia ii and iii and Ib ii and iii

d. Any other conditions of storage

(eg for particular embryos).

Please state

I understand that unless they are used beforehand embryo(s) developed *in vitro* from my egg(s) will have to be allowed to perish at the end of the storage period specified at iib.

DAY MONTH YEAR

**Signature:**

Date: 

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## Reproductive Medicine Unit



Crown Street  
Liverpool L8 7SS  
Tel: 0151 708 9988  
Fax: 0151 702 4028

### Consent to IVF/ICSI/GIFT treatment involving egg retrieval and/or egg or embryo replacement

If telephoning please ask for:

Name of Centre: REPRODUCTIVE MEDICINE UNIT

Address: LIVERPOOL WOMEN'S HOSPITAL

CROWN STREET, LIVERPOOL L8

Direct Line:

[www.lwh.org.uk](http://www.lwh.org.uk)

Full Name of Woman: \_\_\_\_\_

Address: \_\_\_\_\_

This consent form is in two parts. These may be signed separately. When frozen embryos are being replaced they should be signed separately. If treatment involves ICSI, part 111 should also be signed.

#### Part 1.

1. I consent to (delete as applicable)
  - i. be prepared for egg retrieval:
  - ii. the removal of eggs from my ovaries with the aid of:
    - a. laparoscopy
    - b. ultrasound
  - iii. the administration of any drugs and anaesthetics which may be found necessary in the course of the procedure(s):
  - iv. the mixing (or insemination in ICSI see Part 111) of the following (tick each column as required):

<input type="checkbox"/> my eggs	<input type="checkbox"/> with the sperm of my husband/partner
<input type="checkbox"/> eggs donated by: _____	<input type="checkbox"/> with sperm donated by _____
<input type="checkbox"/> an anonymous donor's eggs	<input type="checkbox"/> with an anonymous donor's sperm
2. I understand that eggs are not always retrieved at the time of egg collection
3. I understand and accept there is no guarantee of success in achieving fertilisation or that eggs will develop into embryos
4. I understand that if a donor has given effective consent under the Human Fertilisation and Embryology Act, 1990, the donor will not be the legal parent of any resulting child
5. I have discussed with Dr \_\_\_\_\_ the procedures outlined above. I have been given information orally and in writing about them.
6. I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment. (for GIFT using donated sperm or eggs or any IVF treatment)

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_



I consent to:

i. the placing in my uterus or fallopian tube(s), as may be appropriate, of not more than (tick as applicable):

(a) 1 ( ) eggs mixed with sperm  
2 ( ) " " " "  
3 ( ) " " " "

(b) 1 ( ) embryo(s)  
2 ( )  
3 ( )

ii. The administration of any drugs and anaesthetics which may be found necessary in the course of the procedure(s).

2. I understand that only the egg(s) from one woman and the sperm from one man will be used in any one treatment cycles.
3. I understand that embryos not transferred may be frozen and stored for transfer at a later date.
4. I understand and accept that there is no guarantee of success in achieving a pregnancy and live birth.
5. I have discussed with Dr \_\_\_\_\_ the procedures outlined above. I have been given information orally and in writing about them.
6. Other remarks (if required): \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

7. All information listed in paragraph 4.4 (see overleaf) of the Human Fertilisation and Embryology Authority's Code of Practice has been given to the patient. The patient has been offered a suitable opportunity to take part in counselling about the implications of the proposed treatment.

Doctors signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 111 CONSENT TO TREATMENT INVOLVING INTRACYTOPLASMIC SPERM INJECTION**

1. I consent to the direct intracytoplasmic injection of the following (tick each column as required):-

☐ my eggs

☐ with the sperm of my husband/partner

☐ egg donated by:-

☐ with sperm donated by:-

\_\_\_\_\_  
☐ an anonymous donor's eggs

\_\_\_\_\_  
☐ with an anonymous donor's sperm

2. I understand that the eggs retrieved may not be suitable for injection and the choice of suitable eggs will be made by the ICSI practitioner and that there might also be a risk of damaging the egg during the ICSI procedure.
3. I understand that embryos derived from ICSI and IVF cannot be transferred together in one treatment cycle.
4. I confirm that I have been given the patient information sheet, and that I have read this and understand the risks currently known about ICSI.
5. I understand that male children born as a result of ICSI may themselves have problems with low sperm counts and infertility in adulthood.
6. I confirm that I have been advised to have a test for male chromosomes performed before treatment to reduce any risks associated with this treatment.
7. I confirm that the procedures involved in ICSI have been explained to me both orally and in writing by Dr \_\_\_\_\_ and all questions have been answered satisfactorily.
8. I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Partner/Husband's signature: \_\_\_\_\_ Date: \_\_\_\_\_

I confirm that the patient has been given and understands the patient information sheet and that I have answered any questions to the limit of current knowledge about the risks associated with ICSI.

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

P.T.O.

**HUSBAND'S CONSENT**

I am the husband of \_\_\_\_\_ and I consent to the course of treatment outlined above. I understand that I will become the legal father of any resulting child.

0. Any other remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Husband's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full name in block capitals: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MALE PARTNER'S CONSENT**

11. I am not married to \_\_\_\_\_ but I acknowledge that she and I are being treated together, and that I will become the legal father of any resulting child.

12. Any other remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Male partner's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full name in block capitals: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Note: the centre is not required to obtain a male partner's acknowledgement in order to make the treatment lawful, but where donated sperm is used it is advisable in the interests of establishing the legal parenthood of the child. See paragraphs 5.6 - 5.8 of the code of practice).

Crown Street  
Liverpool L8 7SS  
Tel: 0151 708 9988

## The Hewitt Centre For Reproductive Medicine

If telephoning please ask for:

**To be returned to the Hewitt Centre**

Direct Line:

[www.lwh.org.uk](http://www.lwh.org.uk)

Dear Dr

Your patient has been referred for treatment in our unit. We are obliged by the Human Fertilisation and Embryology Act (1990) to take account of the welfare of any child who may be born as a result of treatment (including the need of that child for a father) and any other child who may be affected by the birth before we provide treatment.

To help us fulfil our obligations we wonder whether you would be kind enough to complete this form.

### Declaration:

I have reviewed the case notes of:

**PLEASE PRINT NAME:**

**Date of Birth:**

.....  
She/He has been my patient for ..... years.

Are there any issues/facts in this patient's social/medical history that should be taken into account before treatment is provided?

Yes / No

If you have answered 'Yes' to the above question, please provide brief details overleaf. Thank you.

Signature: .....

Print name: .....

Date: .....

Practice Stamp.

Please turn over



Details of any issues/facts in this patient's social/medical history that should be taken into account before treatment is provided:

If there are any queries about this form, please contact the Hewitt Centre

---

To be completed by male/female partner if he or she does not wish his/her General Practitioner to complete the form.

Declaration:

I do not wish my General Practitioner to complete the form over the page. I will give a full explanation when I attend for a consultation at the hospital.

Signature: ..... Print name: .....

Date: .....

Crown Street  
Liverpool L8 7SS  
Tel: 0151 708 9988

## The Hewitt Centre for Reproductive Medicine

If telephoning please ask for: .....

**PLEASE RETURN TO THE HEWITT CENTRE**

Direct Line: .....

### Consent to Disclosure of Information

[www.lwh.org.uk](http://www.lwh.org.uk)

1. The implications of consenting to the disclosure of identifying information about my treatment have been explained to me. I understand that I do not have to consent to all or any of the following:-

2. I consent to disclosure of identifying information about my fertility treatment to (specify):

GENERAL PRACTITIONER / REFERRING CONSULTANT for the purpose of

Patient's GP (Please Specify) .....

Partner's GP (Please Specify) .....

3. I consent to disclosure of identifying information about my fertility treatment to another person who needs to know for the purposes of: (please tick as applicable)

( ) My fertility treatment or other medical, surgical or obstetric treatment.

( ) A medical audit

( ) Auditing the Unit's accounts

( ) Health Authority contractual issues

4. I do not consent to disclosure to the following people or for the following purposes:

.....  
.....

5. I do not consent to the disclosure of the following identifying information about my fertility treatment:

.....  
.....

6. I consent to disclosure of the following information only:

.....  
.....

Patients signature: .....

Date: .....

Partners signature: .....

Date: .....



Liverpool Women's Hospital, Crown Street, Liverpool. L8 7SS Tel.No. 0151 708 9988

In Partnership with Aintree Centre for Women's Health



**TO BE RETURNED**

Crown Street  
Liverpool L8 7SS  
Tel: 0151 708 9988

If telephoning please ask for:

Direct Line:

## Accounting for the interests of the child

[www.lwh.org.uk](http://www.lwh.org.uk)

Under the terms of the Human Fertilisation and Embryology Act 1990, any licensed centre offering treatment services that might result in the birth of a child, has to take account of the interests of that child and any other children who might be affected. In order to help us to fulfil these obligations, we would like you to complete and sign this form and ask your GP(s) to sign a declaration form.

You are under no obligation to answer these questions or to consent to contact between the RMU and your GP(s). However, we are required to note any refusal when we take into account the child's interests. All these questions are designed to give us better understanding of your situation.

**All information will be treated in the strictest confidence. If you would prefer to discuss these issues in person we would be happy to do this when you attend the unit.**

Name(s) .....

How long have you been living together? .....

Have you had any children in this or any other relationship? .....

Have you any children living with you at the moment? .....

Have you ever had a child taken into care of the subject of a court order? .....

Are you considering adopting any children? .....

Have you ever had a court conviction for a criminal offence or been investigated for such an offence? .....

Is there a history of any health problems which might influence a pregnancy or your ability to raise a child? .....

Are there any other facts that you think that we ought to know about in making this assessment? .....

Have you ever been treated for or been diagnosed as having depression or any psychiatric illness? .....

All of these questions are designed to give us a better understanding of your situation.



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I/We\* consent to my/our\* family doctor(s) being contacted by the RMU to provide any information they consider to be relevant to the interests of any children being born as a result of any treatment or affected by it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I/We\* consent to my/our\* family doctor(s) being contacted by the RMU Counsellor to provide any information they consider to be relevant to the interests of any children being born as a result of any treatment or affected by it. I/We\* also consent to the Counsellor consulting her colleagues from the local Social Services Departments, should this be required.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

LIVERPOOL WOMEN'S HOSPITAL  
CROWN STREET, LIVERPOOL. L8J 7SS  
TELEPHONE NUMBER: 0151 708 9988

# **WELFARE OF THE CHILD**

## **Information for General Practitioners**

### **This Document Contains Confidential Information**

#### **INFORMATION FOR GENERAL PRACTITIONERS**

Patient name: .....

has approached – The Hewitt Centre For Reproductive Medicine, Liverpool Women's Hospital

with a view to receiving licensed fertility treatment and has consented to you being approached.

#### **LEGAL REQUIREMENTS OF THE LICENSED FERTILITY CLINIC**

Under the terms of the Human Fertilisation and Embryology Act (1990) (HFE Act), any fertility centre in the UK offering treatment services that might result in the birth of a child, such as IVF or use of donated gametes, must take account of:

*'The welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth' (HFE Act 1990, section 13, 5).*

In order to help the fertility clinic fulfil this obligation, we need to ask you whether you are aware of any factual information, medical or otherwise, that you think might be relevant. Relevant information may include health factors relating to your patient and in addition, any other factors that might influence the health or welfare of any resulting child(ren). The information you provide will be one of a number of factors that may be taken into account before any decision to offer treatment is made. The responsibility for making the decision about whether treatment is offered rests with the clinician responsible for administering the fertility treatment.

The HFE Act does not exclude any woman from being considered for treatment. However, in situations where the child will have no legal father the clinic should pay particular attention to the prospective mother's ability to meet the child's needs throughout childhood.

#### **WELFARE OF THE CHILD ISSUES**

*Please note you are not being asked to speculate on lifestyles or on the probability that a patient of yours might behave in certain ways. We are not asking you to assess your patient's suitability to act as parent. You are being asked for relevant factual information, medical or otherwise, within the scope of the information available to you, which you think the clinic needs to know before they consider providing fertility treatment.*

The fertility clinic will be discussing the following Welfare of the Child issues with the patient/couple:

- ◆ Their commitment to having and bringing up a child, or children
- ◆ Their ability to provide a stable and supportive environment for any child produced as a result of treatment

- ◆ Their medical history and the medical histories of their families
- ◆ Their health and consequent future ability to look after or provide for a child's needs
- ◆ Their age and likely future ability to look after or provide for a child's needs
- ◆ Their ability to meet the needs of any child or children who may be born as a result of treatment, including the implications of any possible multiple births
- ◆ Any risk of harm to the child or children who may be born, including the risk of inherited disorders or transmissible diseases, problems during pregnancy and of neglect or abuse
- ◆ The effect of a new baby or babies upon any existing child(ren)

In addition, if the treatment involves the use of donated gametes, the following will be discussed:

- ◆ A child's potential need to know about their origins and whether or not they are prepared for the questions which may arise while the child is growing up
- ◆ The possible attitudes of other members of the family towards the child, and towards the status in the family
- ◆ The implications for the welfare of the child if the donor is personally known within the child's family and social circle
- ◆ An explanation of who will be the legal parents of any child produced as a result of treatment with donated gametes

## CONSENT

This information leaflet contains your patient's written consent for the clinic to contact you and for you to disclose the information they are requesting.

## CONSENT FOR THE GP'S TO BE CONTACTED

I/We\* consent to my/our\* family doctor(s) being contacted by the RMU to provide any information they consider to be relevant to the interests of any children being born as a result of any treatment or affected by it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## CONFIDENTIALITY

If you are concerned in any way about the information you intend to provide, you should discuss this with your patient before responding to the clinic. You need your patient's permission before you can proceed and you should not respond to the clinic without this permission. If you do not have permission to release any or part of the information that you think is relevant you should indicate this to the fertility clinic.

Where necessary, the fertility clinic may make further inquiries of other relevant individuals, authorities or agencies, with the consent of your patient.

## SCOPE OF INFORMATION

It is recognised that you will only be able to provide information within the scope of the records to which you have access and for which you have consent to disclose.

### WHY TREATMENT MAY BE REFUSED

The clinician responsible for administering the fertility treatment is responsible for making the final decision about whether or not treatment will be offered. Treatment may be refused on clinical grounds, or if the clinician believes that it would not be in the interests of any resulting child, or any existing child, to provide treatment. Treatment may also be refused if the fertility clinic is unable to obtain sufficient relevant information or advice to reach a proper conclusion.

If treatment is refused for any reason, an appropriate member of staff at the fertility clinic will explain to the patient (and partner where appropriate) the reasons for this and the factors, if any, which may persuade the centre to reverse its decision. An appropriate member of staff will also explain the options that remain open and will inform the patient (and partner where appropriate) where counselling can be obtained.

### FURTHER INFORMATION

Further information is available from:

***Human Fertilisation and Embryology Authority (HFEA)***

Paxton House  
30 Artillery lane  
London  
E1 7LS

Tel: 0207 377 5077

Website: [www.hfea.gov.uk](http://www.hfea.gov.uk)

You may find it helpful to obtain a copy of the 'Patients' Guide to DI and IVF Clinics' available free by calling the Human Fertilisation and Embryology Authority.