In Vitro Fertilisation (IVF) & Intra-Cytoplasmic Sperm Injection (ICSI)

Leicester Fertility Centre

Information for Patients and Partners

NHS
University Hospitals of Leicester
NHS Trust

What is this leaflet about and who is it for?

This leaflet explains what is involved when undergoing In Vitro Fertilisation (IVF) or Intra-Cytoplasmic Sperm Injection (ICSI). The difference between IVF and ICSI is the way the sperm is used to fertilise the eggs. Your consultant will inform you whether IVF or ICSI is the recommended treatment choice for you.

What is IVF?

IVF is the process of fertilising eggs outside of the body. The eggs and the sperm are mixed together in a dish and are incubated overnight to allow fertilisation to occur. In the event of the sperm quality being insufficient for IVF on the day of egg collection we will discuss the option of ICSI treatment with you.
The main indications for IVF are:

- Age >40 years or more and/or reduced ovarian reserve
- Blocked or damaged fallopian tubes
- Endometriosis
- Borderline sperm parameters
- Unsuccessful Intrauterine Insemination (IUI) treatment

What is ICSI?

ICSI refers to the technique of injecting a single sperm into the mature egg. This helps the sperm to fertilise an egg. Eggs are prepared for injection by removing the outer cells known as the cumulus. A high-powered microscope is used to assess egg maturity (not all eggs will be mature) and the mature eggs are carefully injected with a single sperm.
The main indications for ICSI are:

- Male factor subfertility
- Surgically retrieved sperm
- Failure to fertilise in a previous IVF cycle
- Low fertilisation observed in a previous IVF cycle

ICSI procedure is associated with a small risk of children conceived with ICSI to have inherited genetic, epigenetic or chromosomal

abnormalities (including cystic fibrosis gene mutations, imprinting disorders, sex chromosome defects and heritable sub-fertility)
For additional information about ICSI treatment please refer to https://www.hfea.gov.uk/treatments/explore-all-treatments/intracytoplasmic-sperm-injection-icsi/

What preparation is needed for IVF or ICSI?

Prior to starting your treatment:

1) We require your Body Mass Index (BMI) to be between 19 and 30 to ensure the best response to your treatment. Your BMI is calculated by your body weight in kilograms divided by your height in metres squared. You can use the online NHS Choices BMI calculator to know your BMI. If your BMI is above or below these levels, you can seek support via your GP.
2) An ovarian reserve blood test, known as Anti Mullerian Hormone (AMH), is required, which can be done on any day of the cycle.
3) Screening to check that you have immunity against to German Measles (Rubella).
4) Screening blood tests are required for Hepatitis B and C, HIV 1&2, HTLV 1&2 and Syphilis for individuals undergoing treatment, valid for up to 3 months before commencing treatment. The above health screening is clinic policy for infection prevention and welfare of the child considerations. This means that patients and partners will be required to undergo screening, even if they are not providing gametes. For self-funding patients, the costs of the tests are outlined on our price list which is also available online.
5) If you have a medical condition that has been identified as having an impact on your treatment or pregnancy, you might be referred for anaesthetic review and/or pre-conception counselling and/or other specialist review. Treatment will not be commenced until considered safe.
6) In some cases where there is no sperm in the semen sample or extremely low sperm count, the male partner will need genetic testing to check if there is a genetic reason for it.

What is the procedure?

You will be provided with relevant written information about the treatment process to support your understanding of the consent forms. For further information about the consent forms please visit the Human Fertilisation and Embryology Authority (HFEA) website: http://www.hfea.gov.uk. You will then receive an appointment to discuss and plan your IVF/ICSI treatment.

Before starting the treatment cycle, you will be required to complete the consent forms and given the opportunity to ask any questions.

After this process is completed and you are ready to start your treatment cycle, on the first day of your proper flow of the period you will call the unit on 0116 258 5922 to **book for an ultrasound scan (called as the antral follicle count (AFC) scan)**. This is an internal scan (transvaginal) to count the antral follicles (2 - 6mm in size) on the ovaries, done between days 2 - 6 of the menstrual cycle. This scan will help us to decide the type and dosage of drugs required for you.

If your AFC is less than 5 including in both ovaries, then we will not be able to commence treatment. We will then ask you to call on the first day of your next menstrual cycle. This we can try maximum for three times. If we do not achieve the required count, you will have a medical review. If ready to proceed further, the nurses will then arrange for medication collection and a kit bag. An injection lesson will be arranged if necessary.

Ovarian Stimulation Regimes

Depending upon individual assessment, you will follow a long or short protocol. Patients are advised to avoid unprotected intercourse during treatment. Drug regimes are subject to change depending on availability to suitable alternative, which will not impair treatment outcome.

Long downregulation protocol

After the AFC scan (see above), this involves a daily injection of Buserelin (Suprecur) starting approximately one week before your period is due in order to switch off the pituitary gland which controls your ovaries. The injection is to be administered every morning at the same time before 9:00 am; you will then have a period in 7-14 days. On the first day of proper flow of this period you will call the unit on 0116 258 5922 to book for a **baseline ultrasound** scan and blood test. This is to check that you have responded to the Buserelin injections.

If all is well, in addition to the morning injection, you will be commenced on another daily injection (gonadotrophins) in the evening to stimulate the ovaries. You will be issued with a written plan detailing when your blood test and scans take place over a two-week period to check that your ovaries are responding. The dose of your drugs will be altered dependent on your response.

Short protocol

If your blood tests or AFC on your ultrasound scan suggests that you are more likely to over respond to ovarian stimulation, you will be advised for a short protocol; or if you have not responded well to the long protocol in the previous cycle, you will be offered a short protocol.
After the AFC scan, with the subsequent period you will contact the unit on day 1 of your period (proper flow) to organise a baseline scan and blood test. You then commence your daily gonadotrophin injections in the evening at the same time, before 11 pm. You will then be advised to commence daily Cetrotide or Ganirelix injection in the morning before 9 am, 5 - 6 days after starting the evening injections. You will be issued with a written plan detailing when your blood test and scans take place over a two-week period to check that your ovaries are responding. The dose of your drugs will be altered dependent on your response.

What happens next?

Once the ultrasound scan shows that there are a sufficient number of mature follicles, you will be instructed to administer yourself hormone injection of hCG (Ovitrelle) which matures the eggs before they are collected. You will be advised to administer one or two injections at the

same time. Approximately 36 hours after the hCG injection, the eggs will be removed from the ovaries. The eggs are collected by means of a fine needle being passed through the vaginal wall into the ovaries under ultrasound guidance. You will be given sedation anaesthesia to ensure you do not feel or remember the procedure. The medications that we use for your sedation anaesthesia include: Propofol, Alfentanil, Midazolam; these medications make you drowsy and provide pain relief. Diclofenac suppository can also be given rectally to provide pain relief for up to 18 hours after your egg collection.

On the day of egg retrieval your partner will be required to produce a sperm sample at home. **We advise a sexual abstinence of 2 or 3 days prior to producing a sperm sample**. Once the sample is provided, our embryology team will analyse and prepare, so that the best sperm are isolated and used to inseminate your eggs.

Common side effects of medication

Suprecur/Ganirelix/Cetrotide: Tiredness, headache, hot flushes, irritability and injection site irritation – redness, swelling, bruising or pain.
Gonadotrophins: Headache, tiredness, nausea, vomiting, diarrhoea, abdominal discomfort, bloating and injection site irritation – redness, bruising, swelling or pain. Multiple pregnancy. OHSS – see below.
Hcg Trigger (Ovitrelle) – Headaches, tiredness, Breast pain, Diarrhoea, local skin reactions at the injection site, abdominal discomfort, bloating, nausea and vomiting. Multiple pregnancy. OHSS – see below.
Doxycycline: (an antibiotic to be taken for 5 days after egg collection to help prevent any infection developing). May cause nausea, vomiting, diarrhoea, oesophageal irritation and photosensitivity.
Progesterone: Drowsiness, Abdominal discomfort and or distention, constipation, breast pain, hot flushes.

Please read the information leaflets provided with your medication and if you have any concerns please discuss with the nurses/doctor.

Blastocyst Culture

Blastocyst or extended culture is the term used when the embryos are cultured for five days following the egg collection. The embryo at this stage of development is known as a blastocyst and will have many cells, usually more than 100. The best blastocyst is then transferred into the uterus on the fifth day following the egg collection. Extended culture gives us a greater chance of selecting higher quality embryos, which in turn leads to a higher rate of implantation. Furthermore, blastocyst transfer on day five mimics more closely the timing at which an embryo would reach the uterus in natural conception.

The risks of blastocyst culture include:

1) No embryos developing into a blastocyst resulting in no embryo transfer. Blastocyst culture is therefore only suitable for patients who have one-two good quality embryos depending on the number of eggs fertilised.
2) Increased risk of monozygotic (identical) twins following extended culture
3) Unknown long-term risks of extended culture of embryos *in vitro*.

How are my embryos put back?

On the second, third or fifth day after the egg collection, you will have one or two of the best embryos transferred into the uterus through the cervix. Three embryos may be transferred in exceptional circumstances, for patients over 40 years who have already had multiple unsuccessful cycles.

You will need to have a full bladder at the time of the embryo transfer. This is a painless procedure and does not require any anaesthetic.

A speculum will be inserted, just like a smear test. The doctor will then clean around the cervix and a fine tube 'catheter' is then passed though the cervix into the womb. At this point a nurse will start to scan your tummy to visualise the lining of the uterus. The embryo(s) are replaced with a small amount of media, which can often be seen as a

“white flare” on the screen. The catheter is then removed and checked by the embryologist to ensure the embryo(s) have been replaced.

After the procedure you can go to the toilet and you will be given instructions to follow until the pregnancy test, o support the womb lining to encourage implantation you will be asked to use progesterone pessaries vaginally twice a day starting from the morning after egg collection. Additional progesterone support in the forms of injections may be advised.

Leicester Fertility Centre is unable to guarantee that your treatment will be carried out by a specific doctor. Please let us know before starting treatment/medications if you would not like to proceed with the treatment unless a specific doctor is available.

What happens with the other embryos?

We have the facility for embryo freezing and this will be offered to you to store suitable 'spare' good quality embryos for your own future use. Embryos can be stored for up to 55 years by consenting to periods of up to 10 years at a time.

Please note that if you are using donor gametes/embryos the storage and training/research periods depend upon the wishes of the donor.

When can I do a pregnancy test?

You will be given a date to carry out a urine pregnancy test at home and to contact the unit with the result.

1. If your test is positive you will need to collect further medication and have a blood test the following week.
2. If negative but your period has not started, a blood test will be organised that day to confirm the urine result.
3. If negative but your period has started, a follow-up appointment will be arranged.

What risks are involved?

Cancellation of treatment cycle due to poor or excessive response to the medications.

Ovarian Hyperstimulation Syndrome (please see below)

Egg Collection

The egg collection involves sedation anaesthesia and therefore it is important that you tell us about any other medical conditions that you have or medications that you may be taking.
Most common are abdominal pain/discomfort and mild vaginal bleeding/discharge.

Anaesthetic side effects include postoperative nausea and vomiting (usually last for 1-2 hours and can be controlled with medications), postoperative shivering, chest infection (very rare with sedation anaesthesia), awareness (becoming conscious during some part of operation; the majority of patients who are aware do not feel any pain, but may have memories of events in the operating theatre), allergic reaction to anaesthetic, very rarely anaphylaxis (risk is 1 in 10,000), risk of death or brain damage during anaesthesia (in general the risk is 1 in 100,000 but should be even rarer in sedation for minor procedures.

There is a very small risk of pelvic infection after the egg collection. Symptoms include fever, moderate to severe lower abdominal pain or smelly vaginal discharge (rare).

Vaginal bleeding/Vaginal laceration requiring stitches (very rare).

Injury to bowel, bladder, pelvic blood vessel or nerve (very rare).

There is a potential of not obtaining any eggs despite there being good size follicles present at the monitoring scans. Whether NHS or self-funded treatment, this is considered as a completed cycle.

When ICSI is carried out there is a risk of damage to the eggs (approximately 5-10%) due to the injection procedure. Damaged eggs cannot be used for treatment. Therefore, there can be reduced number of eggs being available for treatment (compared to IVF) due to eggs being immature or damaged by the process of ICSI.

Very rarely, some eggs or embryos could be lost by accident due to human error.

Failure of eggs to fertilise (IVF or ICSI) which would result in the cycle ending without an embryo transfer. For NHS funded cycles, the funding is completed with failure of eggs to fertilise. In cases where the sperm parameters are extremely low, risk of low or no fertilisation is higher.

Failure of embryos to cleave (divide) which would result ending of your cycle. For NHS funded cycles, the funding is completed

Difficulty with embryo transfer or failure to transfer embryo.
Biochemical pregnancy/miscarriage/ectopic pregnancy.

Multiple pregnancy – a multiple pregnancy carries more risks to the mother and baby compared to a singleton pregnancy. Monozygotic (identical) twins can occur even after transfer of a single embryo.

With multiple pregnancy there is a higher risk of miscarriage and higher rate of complications during pregnancy, such as premature birth, low birth weight, still birth, perinatal mortality, disability and other health problems. Also there might be the need for extended stays in hospital before and after birth. There is also the practical, financial and emotional impact of multiple pregnancy on the family and any children.

You can view our verified multiple birth rate data on the HFEA website. The most up to date figures for multiple pregnancy rates can be obtained upon request from our Embryology team or via the laboratory noticeboard in the clinic.

Ovarian hyperstimulation syndrome (OHSS):

OHSS occurs when there are too may follicles produced in the ovary. In severe cases, fluid can collect in the abdomen and chest causing discomfort and difficulty in breathing. This may lead to a greater tendency for the blood to clot causing thrombosis. You may require hospital admission if you are unwell with OHSS.

How do I know if I'm developing OHSS?

The following are symptoms that you may develop as a result of OHSS:

- **Mild OHSS** – mild abdominal swelling or bloating, abdominal discomfort, and nausea. You will be advised to drink plenty of oral fluids at home and report to us if you have other symptoms or if your symptoms get worse.
- **Moderate OHSS** – symptoms of mild OHSS but the swelling and bloating is worse because fluid is building up in the abdomen. There is abdominal pain/ vomiting/and or passing small amount of urine.
- **Severe OHSS –** symptoms of moderate OHSS plus extreme thirst and dehydration because so much fluid is building up in the abdomen, passing very small amounts of urine which is very dark in colour (concentrated), difficulty breathing because of build-up of fluid in the chest and a red, hot, swollen and tender leg due to a clot in the leg or lungs (thrombosis).
- **There have been reports of death following OHSS, although rare.**

If you develop any of these symptoms, then you should contact the unit/Fertility Specialist Nurses on 0116 258 5922. If outside clinic hours, please use the emergency mobile number 07921 545571.

What will happen then?

Fertility Centre staff will arrange for you to be reviewed by the nursing and medical staff in the ACU during working hours or at the

Gynaecology Assessment Unit (GAU) at the LRI out of hours. Sometimes it is necessary to recommend admission to hospital to closely monitor and observe you. It may be necessary to give you blood-thinning injections to prevent clotting and intravenous fluids to correct dehydration and urine output. Rarely, if there is a large fluid collection in the tummy and/or chest it will be drained by a tube to reduce discomfort.

If an admission is recommended to you, you should follow medical advice.

Can anything be done to stop me developing OHSS?

Prior to starting treatment: if you are at a higher risk of developing OHSS as determined by high AMH/known history of PCOS/ younger age group, you will be considered for a short protocol to stimulate the ovaries.

During treatment: At the time of the final scan (before the hCG injection (Ovitrelle)) we will have a reasonable estimate of the number of eggs that are likely to be collected. You will be informed if we think you are at increased risk of developing OHSS. Measures taken to reduce the risk of OHSS depends upon individual circumstances, however these are:

a) Rarely, we may decide to cancel your egg collection if we think that the risk of developing severe OHSS is very high. In this case we will ask you to stop your gonadotrophin injections and restart in few months with a different protocol to stimulate the ovaries. Sometimes, when a high number of eggs is expected, we may decide to do egg retrieval, create embryos, and freeze them for future use (there is no fresh embryo transfer). With no embryo transfer, this is often called as 'freeze all'. This will be based on your symptoms and clinical judgment either on the day of the final scan or on the day of egg collection

b) If the decision is for 'freeze all', sometimes you are prescribed a different medication for 'trigger' instead of the hCG injection. You need to follow the instructions carefully as explained by the nursing staff.

c) After a 'freeze all', embryo transfer is planned in the next few months.
d) You may be placed on a medication called Cabergoline, which reduces the risk of developing OHSS, for eight days from the day of egg collection. We will give the prescription from the hospital and the medication needs to be collected from the hospital pharmacy. There are no major side effects of this medication.

Rescue ICSI

Rescue ICSI (rICSI) is a procedure that can be used in the event of complete fertilisation failure following IVF, or in the event of no mature eggs being retrieved for ICSI. The technique involves injecting mature eggs that show no signs of fertilisation the day after egg collection. If fertilisation and subsequent good quality embryo development occurs, the embryos will be frozen for use in a future frozen embryo transfer cycle. They cannot be used in the same fresh cycle as they will no longer be in synchrony with the endometrium. There are limited reports on live birth outcomes, and no long term evaluation of children resulting from rICSI has been performed. The procedure carries the same risks as conventional ICSI however; there is evidence that there is a slightly raised chance of abnormal fertilisation. Embryos showing abnormal fertilisation would not be transferred.

SpermMobil

SpermMobil is a solution used during ICSI when sperm show little or no movement (motility). It temporarily stimulates motility, helping the embryologist identify viable sperm for injection, reducing the time eggs are outside the incubator. It may be beneficial for patients with very low or absent sperm motility, particularly when sperm have been surgically retrieved from the testicles. SpermMobil is not currently CE marked for medical use but may be used where clinically appropriate with patient consent. It has been used in fertility clinics nationally and internationally, with successful live births reported. Although there is currently no evidence of an increased risk of adverse outcomes in children born following its use, long-term follow-up data remains limited and therefore its use is restricted to selected patients where a potential clinical benefit exists.

What are treatment ‘add-ons’?

Add-ons are optional extras that may be offered on top of your normal fertility treatment. They are emerging techniques that may have shown some promising results in initial studies but haven’t necessarily been proven to improve fertility outcomes, such as live birth rates.

Our clinic does not charge for the add-ons embryo glue and time lapse monitoring. The cost is included with our treatment packages as standard. To make it easier to identify which add-ons have evidence supporting their effectiveness and safety and which have very little evidence, or should be considered experimental, the HFEA have created a range of symbols and colours for each rated add-on - please refer to the next page for details.

More information about add-ons and the most up to date rating for each individual add-on can be found at the HFEA website: **https://www.hfea.gov.uk/treatments/treatment-add-ons/**

On balance, findings from high quality evidence shows **this add-on is effective at improving the treatment outcome**.

On balance, it **is not clear whether this add-on is effective at improving the treatment outcome**. This is because there is conflicting moderate/high quality evidence – in some studies the add-on has been found to be effective, but in other studies it has not.

We cannot rate the effectiveness of this add-on at improving the treatment outcome as there is insufficient moderate/high quality evidence.

On balance, the evidence from moderate/high quality evidence shows that **this add-on has no effect on the treatment outcome**.

There are potential safety concerns and/or, on balance, the findings from moderate/high quality evidence shows that this **add-on may reduce treatment effectiveness**.

Embryo glue

Embryo glue contains a natural substance called hyaluronan, which may improve the chance of the embryo implanting in the uterus. It is added to the solution in the dish in which the embryos are kept before embryo transfer.

Are there any risks?

There are no known risks from using embryo glue.

What's the evidence for embryo glue?

Research from Cochrane reviews shows that embryo glue containing hyaluronan increases pregnancy and live birth rates by around 10%. There is one high quality study in this review which shows that the use of embryo glue improves pregnancy and live birth rates. Other studies in the review were of moderate quality. Further high-quality studies are needed before the benefits of embryo glue are proven.

Endometrial scratch

In order to have a successful pregnancy, an embryo needs to 'implant' in the uterus. In a small number of cases, implantation does not occur due to environmental factors in the lining of the uterus. Endometrial scratch carried out before IVF is intended to help with the environment for implantation. During the procedure the lining of the uterus (the endometrium) is 'taken away' using a small sterile plastic tube called as a 'pipelle'. The procedure is done in the cycle preceding your IVF stimulation medications.

The theory is that this procedure triggers the body to repair the site of the scratch in the lining, releasing chemicals and hormones that make the uterus lining more receptive to an embryo implanting. Some research suggests the treatment may activate genes that make the uterus lining more receptive to an embryo implanting. If you have discussed endometrial scratch with your doctor, you can get detailed information in our information leaflet on 'Endometrial Scratch'.

Are there any risks?

There is a small risk of causing infection to the lining of the uterus. Your clinic can treat this if necessary.

What's the evidence for endometrial scratching?

Current evidence does not support the routine use of endometrial scratching for women undergoing IVF. Some studies have shown an improvement in live birth rate; however, further evidence is needed before the benefits of endometrial scratching can be confirmed.

Time-lapse imaging

In conventional IVF, the embryologist checks the developing embryos daily under a microscope, which involves removing them from the incubator for a brief period. Time-lapse imaging is used to help select the embryos most likely to successfully develop into a baby.

Time-lapse imaging allows the embryologist to take thousands of images of the embryos as they grow without disturbing them. Not only does this mean the embryos do not have to be removed from the incubator, it also allows the embryologist to get a continuous view of each embryo as it develops, rather than just viewing them once a day.

The embryologist can then choose a specific embryo for implantation based on criteria such as rate of development and the number and appearance of cells. Indeed, being undisturbed while they grow may improve the quality of the embryos.,

Are there any risks?

No, there are no known risks to the woman or her embryos from time-lapse imaging.

What's the evidence for time-lapse imaging?

There have been various studies to try and see if time-lapse imaging can improve birth rates. Initial research has shown some promise, but it's still early days. There's certainly not enough evidence to show that time-lapse imaging improves birth rates, which is something you may want to consider if it's being offered to you at an extra cost.

Pre-implantation genetic testing for aneuploidy (PGT-A)

PGT-A involves checking embryos for abnormalities in the number of chromosomes. Embryos with an abnormal number of chromosomes (known as aneuploid embryos) have less chance of developing into a

baby or, less commonly, may result in a baby being born with a genetic condition. PGT-A identifies aneuploid embryos that are unsuitable for fertility treatment. For more information relating to the risks and the evidence for PGT-A, please refer to our Pre-implantation genetic testing for aneuploidy (PGT-A) patient information booklet.

What follow up care is available after our IVF or ICSI cycle?

We would normally offer you and your partner a follow-up appointment if your treatment has not been successful. We understand that this is a very difficult time for you both emotionally. Should you wish to access any supportive counselling during your fertility treatment you may wish to contact the Leicester Fertility Centre to arrange an appointment with the unit's counsellors.

The use of eggs, sperm, or embryos for training

At the end of your treatment cycle there may be unused sperm, unfertilised eggs and embryos that are unsuitable for freezing. On your HFEA WT & MT consent forms you have the option to allow eggs/ sperm/ embryos to be used for training purposes prior to their discard. Please note that it is not possible to consent to use in training or research without consenting to storage.
You can either consent to 'no' in which case the eggs/ sperm/ embryos that were not used in your treatment will be discarded, or you can consent to 'yes'. If you are being treated with your partner, then you both must agree on what is to happen to your embryos.

If you consent to 'yes' for training, then nothing will be done until the end of your treatment cycle. You can withdraw your consent at any time prior to their use in training. There is no financial benefit from consenting for your eggs/ sperm/ embryos for training. Selecting either 'yes' or 'no' for the use of your sperm/ eggs/ embryos for training will not impact on the care you receive. You can also consent to allow samples to be stored for use in training in the future, which may enable more staff to benefit. The forms also allow you to specify your wishes

about training in the event of death and mental incapacitation separately.

Your consent forms will be checked prior to treatment and your wishes will be logged on the laboratory paperwork. If, at the end of your treatment cycle, the eggs/ sperm/ embryos are to be used for training purposes then two members of the embryology team will recheck the HFEA WT and MT consent forms to confirm that valid consent is in place. To ensure no conflict of interest, if the staff member who carried out the assessment of fertilisation or development would also be the one using the samples in training, then the grading would be confirmed by another qualified member of staff by review of the timelapse footage.

Any eggs/ sperm/ embryos to be used in training will be transferred to a new container and kept in a separate incubator space to any eggs/ sperm/ embryos in use. A log is kept of all eggs/ sperm/ embryos used for training, including which staff member has used them and for what technique. The eggs/ sperm/ embryos could be used for the purpose of training staff in embryo biopsy, embryo storage or other embryological techniques as per the HFE Act 2008 (for example moving embryos or eggs from one dish to another or egg injections). We would not attempt to create any embryos when training with eggs and sperm. The gametes would also not be used to 'test' or 'validate' equipment as per the HFE Act 2008. Patients using donor sperm and/or donor eggs may / may not be able to donate their embryos for training depending on what the donor has consented to. If you wish to find out if your donor has consented to training, please speak to a member of the clinical team.

As not all eggs/ sperm/ embryos available from patients who consented to training are required by staff, it is not guaranteed that samples will always be used in training. If you would like to know, after your treatment cycle is complete, you can ask if your samples were used and for what technique. Once the training has been completed the eggs/ sperm/ embryos would be discarded and not used for any other purpose. By allowing your eggs/ sperm/ embryos to be used for training you are helping the embryologists and patients of tomorrow and we thank you for your help.

Our commitment to patients

We are constantly striving to improve our services to patients, and we will welcome your comments or suggestions for improvement.

Leicester Fertility Centre Contact Details

Tel: 0116 2585922

E-mail: uhl-tr.leicesterfertilitycentre@nhs.net
Website: www.leicesterfertilitycentre.org.uk

Useful addresses

Human Fertilisation and Embryology Authority: www.hfea.gov.uk

www.hfea.gov.uk/treatments/explore-all-treatments/risks-of-fertility-treatment

www.hfea.gov.uk/treatments/fertility-preservation/embryo-freezing

NICE guidelines: www.nice.org.uk

NHS - Response line: 111.nhs.uk / 111

NHS - Smoking helpline: 0300 123 1044

Fertility Network UK: www.fertilitynetworkuk.org / 0121 323 5025

Do you feel that you are at risk of verbal or physical abuse? If so, you may find the following numbers useful:

Domestic Violence Helpline:

United against violence & abuse (UAVA)

Helpline:	0808 802 0028
Email:	info@uava.org.uk
Text support:	07715 994 962

This information was correct at the time of printing. While the Trust makes every reasonable effort to keep its information leaflets up to date, very recent changes may not be reflected in the guidance and you should discuss this with the clinical staff at the time of your appointment.

Questions

If you have any questions write them down here to remind you what to ask when you speak to your consultant.

Today's research is tomorrow's care

We all benefit from research. Leicester's Hospitals is a research active Trust so you may find that research is happening when you visit the hospital or your clinic.

If you are interested in finding out how you can become involved in a clinical trial or to find out more about taking part in research, please speak to your clinician or GP.

If you need information in a different language or format, please call the number(s) below or email equality@uhl-tr.nhs.uk

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

على هذه المعلومات بلغةٍ أُخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل

જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu

0116 258 4382 or 0116 250 2959