Consent

I consent to the use of the below adjuvant drugs as a component of my fertility treatment in accordance with my treating doctor's prescription. I have read through the associated information and side effects regarding these medications and consent to have these as part of my fertility treatment.

I understand that it is my responsibility to notify my specialist and treatment team if I have previously experienced any unusual or allergic reactions to this medication or any other medications. I have been informed of the possible side effects and will promptly notify my doctor in the event of any unusual symptoms.

I acknowledge that my doctor may administer a combination of the listed drugs depending on my treatment plan, at his sole discretion.

I agree not to alter any of the prescribed doses unless explicitly directed to do so by my doctor. I agree not to administer any medications prescribed to me to any other individuals.

- Testogel (Androgen Cream)
- Melatonin
- Aspirin
- Clexane
- Dexamethasone
- Prednisolone
- Intravenous Immunoglobulin (IVIG)
- Filgrastim
- Humira
- Intralipid infusion
- Naltrexone
- Tacrolimus
- Recombinant Growth Hormone (RGH/HGH)
- Viagra
- Progesterone

Name:

DOB:

Signature:

Date: