Southwest Florida Surrogacy Program
General Patient Information, EDI

Introduction:

Surrogacy is a complicated process. These materials have been divided in **General Surrogacy Information** as well as information specific to the **Conventional Surrogacy** and **Gestational Surrogacy** procedures. This information pertains to both those individuals seeking a surrogate and the surrogates themselves. Additional information and databases may be viewed by visiting:

http://www.dreamababy.com/surrogacy.htm

General Surrogacy Information:

Definitions:

Surrogacy Type	Definition
Conventional Surrogacy	The Conventional Surrogate (**CS**) provides both the egg and her uterus to allow for fertilization, gestation and eventual delivery. The child is the genetic product of the surrogate and the male who provided the sperm. This type of surrogacy is sometimes called "Traditional Surrogacy" or "Genetic Surrogacy".
Gestational Surrogacy	The gestational surrogate (**GS**) provides her uterus for gestation and delivery. The child is the genetic product of the individuals who provided the egg and the sperm. In this instance, there is no genetic investment by the gestational surrogate herself.

In these materials, the Gestational and Conventional Surrogacy ***procedures*** will not be abbreviated. The **C**onventional **S**urrogate, however, will be abbreviated as **CS** while the **G**estational **S**urrogate will be abbreviated **GS**. The individual(s) seeking surrogacy will be described as the **Commissioning Couple/Intended Parent**.

Surrogacy Overview: A Historical Perspective:

12611 World Plaza Lane, Bldg. 53 • Fort Myers, Florida 33907 USA
Info@EmbryoDonation.com • www.EmbryoDonation.com
800-334-2184 • 239-275-5728 • 239-275-5914 (fax)

Many think surrogacy is a new technological advance, but this is not correct. Conventional Surrogacy dates back to biblical times when Sarah (wife) was unable to bear Abraham (husband) a child, she provided him with her maid Hagar (CS) to bear the child for her (Genesis 16.1-4). In this example, the CS provided both the egg and the uterus and the offspring was a genetic mix of the genetic surrogate and Abraham.

While Conventional Surrogacy has been around for a very long time, it took mankind many years to perfect science to be able to preform In Vitro Fertilization (IVF) and Gestational Surrogacy. The first Gestational Surrogacy procedure was reported in 1985 (Utian WH, et al. Successful pregnancy after in vitro fertilization-embryo transfer from an infertile woman to a surrogate. N Engl J Med 1985;313:1351). In this particular instance, the woman's uterus had been removed but the ovaries remained in place. The couple was able to produce an egg and sperm that formed an embryo through IVF techniques. The embryo was then transferred into a host uterus (i.e., the GS) for continued gestation and eventual delivery. In this particular instance, the GS did **not** have a "genetic investment" in the pregnancy.

Egg Donation in Combination to Gestational Surrogacy:

There is yet another twist to the two types of surrogacy outlined above. If the female partner of the infertile couple is not only missing her uterus but she is also missing or has poorly functioning ovaries, another woman (usually an anonymous Egg Donor) can become involved by donating her eggs. The donated eggs are combined with sperm with the resulting embryos transferred into the GS. While seemingly complex, this process is technically no more difficult than for routine Gestational Surrogacy and often the preferred method of choice to minimize the issues of "genetic investment" as found in Conventional Surrogacy procedures.

What are The General Indications For Surrogacy?

This can get a bit confusing, but your reproductive specialist here at Embryo Donation International (**EDI)** will discuss the clinical indications in greater detail. Here is a general summary of surrogacy indications although there will certainly be variations of circumstances beyond those listed below:

Circumstances	Conventional Surrogacy	Gestational Surrogacy	Egg Donation With Gestational Surrogacy
Heterosexual Couples			
Absent/malformed uterus but viable eggs present†		●	
Absent/malformed uterus & without eggs	●		●
Recurrent pregnancy loss	●	●	
Pregnancy contraindicated	●	●	
Same Sex Couples			
Male-Male	●		●
Female-Female	●	●	●
Single Individuals			
Male	●		●

Single female without uterus but with viable eggs*		•	
Single female without uterus & without viable eggs*	•		•

†: "Eggs Present" generally means that the woman is less than 40 years of age.

*: Donor sperm will also be needed.

Our Philosophy Here at EDI In Deciding When Surrogacy Is Appropriate:

Surrogacy is a very serious process. It is not indicated for non-medical reasons. As an example, it would be inappropriate for us to recommend surrogacy so that a model would not get any "stretch marks" during a pregnancy. It should always be remembered that the surrogate undergoes procedures which have a potential, however limited, for complications. Pregnancy itself is sometimes complicated by unexpected events with an estimated 20-25% of all pregnancies delivered by Cesearian Section. Pregnancy confers a level of risk which should always, whenever possible, be assumed by the individuals wanting a child. For this reason, we here at EDI feel that surrogacy should only be performed for non-frivolous indications. We hope that you will agree.

How Do We Find A Surrogate?

Many women of child-bearing age have the potential to be a surrogate. Below are some of the general and procedure-specific characteristics we look for. All ethnic backgrounds are desired and encouraged to apply.

Surrogacy Type	Highly Desired	Acceptable	Not Desired
Common for Both Conventional & Gestational Surrogacy	• Completed childbearing • No previous obstetrical complications • No history of sexually transmitted diseases • Partner agrees to procedure • Friend or family member of the Commissioning Couple/Intended Parent • Delivery covered by insurance • Willing to deliver in Florida	• Never pregnant • Previous obstetrical complications • History of cured sexually transmitted diseases • Delivery not covered by insurance • Willing to deliver in a surrogacy-friendly state.	• Significant psychiatric history • Previous history of severe obstetrical complications • Has an active sexually transmitted disease • Partner does not agree to the procedure • Only willing to deliver in a surrogacy-prohibitive state
Conventional Surrogacy	• Age 18-31	• Age 32-39	• Age ≥ 40
Gestational Surrogacy	• Age 18-39	• Age: 40-55	• Age ≥ 55

Florida is a particularly surrogacy-friendly state. If you are interested, please visit:

http://www.dreamababy.com/surrogacy_fl-safe.htm

There are some other states, however, which forbid surrogacy. It starts getting a bit more complicated when the contracts are drawn up here in Florida but the surrogate eventually delivers in another state. The Commissioning Couple/Intended Parent and the surrogate themselves are encouraged to seek legal

representation to have these and others legal questions answered. While you may certainly find your own, we commonly work with local attorneys with greater information available by visiting:

http://www.LegalSurrogacy.com

Some intended parents/couples find their own surrogate. We here at EDI often have requests from women who also want to become surrogates. If needed, we can place ads in local papers and magazines requesting surrogates. For simplicity, we prefer the surrogates to live locally but have worked with others at far greater distances.

How Is The Surrogate Evaluated?

Here are numerous levels of evaluation that a prospective surrogate must complete before being accepted into our program. While these are listed below in a chronologic order, it is quite common for some of the levels be examined simultaneously and not necessarily in a step-by-step fashion. The levels of evaluation are designed in that the likelihood of a surrogate being rejected or herself deciding to terminate the evaluation becomes less likely as she progresses through the process.

Level I:

The prospective surrogate is requested to complete and mail an **Egg Donor/Surrogate Identifying Information Application.** The information will be reviewed by the In Vitro Fertilization (IVF) Nurse Coordinator who may clarify any concerns by phone. Once accepted, the applicant's information will then be posted on our website and will then remain on the waiting list until chosen by a Commissioning Couple/Intended Parent.

Level II:

Once a prospective surrogate is chosen by a Commissioning Couple/Intended Parent, the prospective surrogate will then be asked to meet the IVF Nurse Coordinator and additional materials will be provided to the potential surrogate and reviewed in detail. If the surrogate agrees, she will move onto the next steps.

Level III:

A Criminal History Check is initiated on the surrogate. It can take a number of weeks for the information to return to EDI.

Level IV:

It is generally recommended that Commissioning Couple/Intended Parent and the surrogate meet each other although some individuals prefer to wait until other levels have been successfully completed. Simply stated, surrogacy is a very *personal* process and it is encouraged that the participants begin to form a *relationship*. If they feel compatible, they should move to the next level.

Level V:

A psychological evaluation will be performed to evaluate the potential surrogate's understanding of the overall process as well as her motivation. This is a relatively brief but important part of the evaluation process.

Level VI:

A history and physical exam will be performed by EDI.

Level VII:

Blood tests, urine drug testing and various cultures will be obtained to make certain that the surrogate is healthy. When available, some blood tests may also be required on the surrogate's partner. Some type of procedure is performed to evaluate the uterine cavity,

Fallopian tubes and the pelvis in general to make certain the conditions are optimal for a healthy pregnancy and delivery.

Level VIII:

The surrogate and the Commissioning Couple/Intended Parent generally have separate legal representation. Legal contracts are reviewed, modified if necessary and then signed. All legal fees are paid for by the Commissioning Couple/Intended Parent.

Level IX:

The prospective surrogate's file is presented to the Assisted Reproductive Technologies Team at EDI and a final decision made regarding specific protocols and procedures. The surrogacy participants are notified of the outcome of this meeting.

Level X:

All legal issues are solidified and copies of the agreement are provided to EDI.

What Tests are Performed on the Surrogate?

The type of tests performed on a surrogate is listed below and are somewhat dependent upon the type of surrogacy performed. Essentially, if a conventional surrogate is providing her eggs, we must check her inheritance and egg quality issues in greater detail. Otherwise, the evaluation is generally similar between the gestational and the conventional surrogate.

Test	Common Name Of The Test	Gestational Surrogates (Initial Testing)	Conventional Surrogates (Initial Testing)	Surrogate's Partner
FSH	Follicle Stimulating Hormone		•	
Cystic Fibrosis	Genetic Disease Testing		•	
Genetic Testing	Additional Genetic Testing may be requested		•α	
Criminal History Check	Examines for past criminal behavior.	•	•	
Psychological Evaluation	Personality Evaluation	•	•	
HIV I & II	Human Immunodeficiency Virus	•	•	•
HTLV 1 & 2	A different strain of the HIV virus	•	•	•
HBsAg	Hepatitis B Surface Antigen	•	•	•
HCsAb	Hepatitis C Surface Antibody	•	•	•
RPR	Syphilis	•	•	•
CMV	Cytomegalovirus	•*	•*	
GC/Chlam.	GC/Chlam	•	•	
HSV I/II	Culture for Herpes Simplex, I/II	•	•	

Urine Drug Testing	Tests for recreational drug use	●	●	
ABO	Blood Type	●	●	
Antibody Screen	To make certain no antibodies are present that could harm the pregnancy	●	●	
Chemistry	Chemistry Profile	●	●	
CBC	Complete Blood count	●	●	
Rubella Screen	To make certain surrogate is immune to German Measles	●	●	
Varicella Screen	To make certain surrogate is immune to chicken pox	●	●	
PAP Smear	Screening test	●	●	
Progesterone	Ovulation confirmation	●	●	
Cavity Evaluation	Making certain the uterine cavity is normal	●†	●†	

●α: Additional genetic testing may also be recommended on the conventional surrogate depending upon her race and ancestry.

●*: May not be retested every six months if the surrogate is positive for a past exposure to CMV (causes the common cold).

●†: The method of evaluation may include a hysterosalpingogram, diagnostic hysteroscopy, pelvic ultrasound or saline infusion sonography

All disease-specific laboratory testing and urine drug testing will be updated every six months. Other evaluations such as PAP smear and exam are good for one year with uterine cavity evaluations generally good for two years. Criminal History Checks are also good for two years.

Who Undergoes a Criminal History Check?

All surrogates undergo a Criminal History Check (CHC). While not exhaustive, this will give a detailed review of any past criminal behavior. An Intended Parent that wants to raise a child alone also undergoes a Criminal History Check. While it is not uncommon for a single individual to raise a child alone in our society, it is understood that single parents are at a higher risk of inflicting child abuse and/or neglect. A single parent, therefore, constitutes an "at risk" population. If the single parent also has a violent criminal history, there may be compounded risks to the child. It is our intent to do whatever possible to protect the child and minimize the possibility of placing a child in an environment at risk for abuse/neglect.

Parenting Classes for Intended Parent

We ask that all single Intended Parents attend parenting classes if they have not raised a child in the past. As always, our goal is to protect the child born from a surrogacy procedure. As stated above,

single parents are at higher risk of inflicting child abuse and/or neglect, so parenting classes are required.

Who Pays For The Evaluation and Is The Surrogate Paid Here In Florida?

The Commissioning Couple/Intended Parent will reimburse all evaluations, medical, legal and delivery expenses during the surrogacy process. Specific details regarding this financial arrangement will be determined by the attorneys representing each party.

Due to Florida state statutes, the surrogate can not be directly paid for being a surrogate but she is often reimbursed for reasonable living expenses incurred during the entire process. It is important; therefore, that the decision to participate in the program by the surrogate not only be solely based on monetary concerns.

Does The Surrogate Have Any Legal Rights Or Responsibilities To The Offspring?

Florida statutes currently provide that upon the GS does not have any legal rights or responsibilities towards the child once it is born. The GS, however, retains all rights during her evaluation, embryo transfer process, gestation and delivery to make all medical decisions without interference. Details of this arrangement will again be discussed in the legal contracts.

Florida statutes indicate that the CS retains her rights to make decisions throughout the pregnancy but specific legal proceedings are initiated following the delivery of the child wherein she relinquishes all responsibility for the child.

It is so important to find the right surrogate. While rare, about one in 20 women refuse to relinquish the child after birth with conventional surrogacy procedures. (Akker O, 1999) This is even less with gestational surrogacy with/without egg donation.

What Questions Should Be Asked Of A Surrogate?

Here are a few questions that may want to be covered, perhaps in the legal contracts, between the Commissioning Couple/Intended Parent and the Conventional Surrogate:

- How many fetuses is the surrogate willing to carry?
- Would the surrogate be willing to quit smoking, drinking alcohol and using recreational drugs before and during the pregnancy?
- If the surrogate lives a distance away, is she willing to travel to complete the surrogacy process?
- Does the surrogate have medical insurance that covers obstetrical care and does it specifically exclude surrogacy?
- If the surrogate has small children, will she be able to make adequate childcare arrangements when necessary?
- Is the surrogate's partner willing to help prevent an unintended pregnancy when surrogacy is being performed?
- What kind of contact will be present between the Commissioning Couple/Intended Parent and the surrogate during the pregnancy and delivery?

- Can the Commissioning Couple/Intended Parent suggest who the surrogate sees for her obstetrical care?
- What kind of support systems does the surrogate currently have?
- Is the surrogate willing to undergo a genetic amniocentesis if the Commissioning Couple/Intended parent and physician feel it is necessary?
- Is the surrogate willing to abort an abnormal fetus?
- What will the surrogate tell her family and friends?
- Is the surrogate willing to undergo a Caesarean Section for the birth of the child/children?
- What kind of relationship will the surrogate and the child have after the delivery?
- Is the surrogate willing to try more than once to complete the process?
- Do any of the parties involved in the surrogacy have any reservations they are willing to discuss?

Are The Children Normal That Are Created From Surrogacy?

Spontaneous pregnancy losses do not occur more often with surrogacy. Lower birthweight children (< 2500 grams) are much more common with regular Assisted Reproductive Technologies (ART) than Surrogacy. Pregnancy complications such as hypertension, pregnancy-induced hypertension, placenta previa, abruptio placentae and gestational diabetes mellitus are actually *lower* for surrogacy compared to ART (Parkinson J, et al. 1998). Post-partum depression is not more common in the surrogate. If a multiple pregnancy does occur, there are increased risks to both the surrogate and the children although modern medicine continues to deal quite well with the vast majority of issues.

Should We Tell The Child We Used A Surrogate When They Are Old Enough To Understand?

Some Commissioning Couple/Intended Parents keep some sort of relationship with the surrogate following the delivery while others sever their ties. It is difficult, however, having some family and friends know that the child was a product of surrogacy while trying to hide if from the child. These are personal choices by the Commissioning Couple/Intended Parent with input from the surrogate and it is encouraged that these concerns be addressed early in the surrogacy process.

What Happens During The Pregnancy, Delivery and During the Post-Partum Period?

Much of what happens during the pregnancy, delivery and the post-partum period entirely depends upon the contracts that are previously agreed upon. Here are some possibilities:

- After two early ultrasounds here at EDI, the patient is released to the OB/GYN she and the Commissioning couple/Intended Parent have previously agreed upon.
- It is customary for the Commissioning Couple/Intended Parent to reimburse the surrogate for various expenses related to the surrogacy itself including reasonable living expenses, certain pregnancy-related medical expenses not covered by insurance and other surrogacy-related expenses as stipulated in the contract.
- If desired by the surrogate, psychological counseling will be made available during the pregnancy and post-partum period. This is paid for by the Commissioning Couple/Intended Parent per the contract.

- Depending upon the relationship fostered thus far between the surrogate and the Commissioning Couple/Intended Parent, the Commissioning couple/Intended Parent may be invited to attend the delivery.
- Following the delivery, the following will generally take place In the state of Florida:

  Conventional Surrogacy (CS):

  After the consent withdrawal period has expired, the Commissioning Couple/Intended Parent proceeds with a pre-planned adoption court proceeding.

  Gestational Surrogacy (GS):

  The Commissioning couple/Intended Parent can immediately proceed with a court action to affirm their parentage.
- The financial responsibilities between the intended parent/couple and the surrogate may extend up to six weeks post-partum, as stipulated in the contract.

What Are The Costs For The Surrogacy Procedures?

The costs of the basic procedures are quite complex and must be discussed in detail. We have included this information separately for those seeking different forms of surrogacy. Please review your packet of information for specific details (Conventional/Gestational Surrogacy Price Sheet). It is highly recommended that you also schedule an appointment with our Front Office staff to discuss these details.

Having a surrogate with medical insurance is also extraordinarily important. While rare, there is the occasional insurance carrier that specifically forbids surrogacy, so care must be taken in determining insurance coverage.

No matter how skilled the attorney, unforeseen fees and problems can occur. It is important, therefore, that all parties involved in the surrogacy process be chosen carefully so that adversarial relationships will not occur.

Conventional Surrogacy Specific Information:

How is Conventional Surrogacy Performed?

In Conventional Surrogacy (CS), sperm is inseminated at the time of ovulation. In general, the surrogate will check her urine for a surge of hormone (LH: Luteinizing Hormone) indicating impending ovulation. Ultrasonography is sometimes used to further identify the ideal time for the Intra-Uterine Insemination (IUI) process. Either fresh sperm or thawed cryopreserved sperm is specially prepared and placed into the uterus of the surrogate using a slender catheter in a procedure that causes a minimal of discomfort.

How Is The Sperm Screened Prior To Insemination Into The Conventional Surrogate?

It is expected that the male providing the semen will be checked for a number of diseases. Laboratory testing the male, freezing (cryopreserving) of sperm and then retesting the male six months from the original cryopreservation, however, is the general pattern to assure the maximum safety of the surrogate.

The male is asked to provide at least three specimens which are then placed in quarantine. Each frozen semen specimen can often be used in two insemination procedures. The following diseases are examined before the cryopreserved sperm is placed in our general storage tanks:

Test	Common Name Of The Test	Sperm Provider (Initial Testing)	Sperm Provider (Tested Every Six Months)	Partner Of Sperm Provider (Initial Testing)	Partner Of Sperm Provider (Tested Every Six Months)
Semen Analysis	Semen Analysis to make certain sperm is viable	●			
Criminal History Check	Examines for past criminal behavior.	●			
ABO	Blood type	●			
Genetic Testing	Specific testing is patient-specific	●			
HIV I & II$^{\alpha}$	Human Immunodeficiency Virus	●	●	●	●
HTLV 1 & 2	A rare strain of HIV	●	●	●	●
HBsAg$^{\alpha}$	Hepatitis B Surface Antigen	●	●	●	●
HCsAb$^{\alpha}$	Hepatitis C Surface Antibody	●	●	●	●
CMV	Cytomegalovirus	●	●*		
RPR	Syphilis	●	●		
GC/Chlam.	Gonorrhea and Chlamydia urine testing	●	●		
HSV	Herpes Simplex Culture	●	●		

●*: May not be retested if the surrogate is positive for a past exposure to CMV (causes the common cold).

Commonly, the cryopreserved sperm is not used for conventional surrogacy techniques until the above tests have been repeated in six months and are again found to be negative. As stated above, the partner (when available) of the individual providing the sperm will also be tested initially and every six months.

If desired by the participants, fresh sperm can be used in the process. Special arrangements are sometimes made between the surrogate and the Commissioning Couple/Intended Parent to use fresh sperm rather than cryopreserved sperm. Realistically, it is quite unlikely that the individual providing the sperm will suddenly turn up positive for any of the above tests after initial negative results. That stated, the cryopreservation of the sperm with a six-month quarantine process is designed to protect the conventional surrogate as much as possible. With sperm, millions of cells are being inseminated, so the potential of disease transmission is certainly possible.

What are the Success Rates For Conventional Surrogacy?

Under ideal circumstances, the general chances for conception using natural intercourse in young fertile couples are estimated near 20% each month. In the Conventional Surrogacy procedure, the insemination is generally performed only once that month with the statistical chances for success slightly lower than the natural success rates.

The success rates for surrogacy will generally depend upon quality of the sperm, whether the sperm was fresh or thawed, the age of surrogate, the timing of the insemination and the placement of the sperm. On average, the success rates should range between 10 and 25% per attempt. For general comparison, donor sperm insemination success rates are often quite similar to the conventional surrogacy success rates. Both the surrogate and the Commissioning Couple/Intended Parent need to be aware that it may take a few attempts before success is achieved.

The length of time the sperm can remain frozen and then successfully thawed is uncertain but most likely ranges from 10-20 years This cryopreserved specimen can also be transported anywhere in the world making it ideal for use in distant surrogacy facilities.

Gestational Surrogacy Specific Information:

How is Gestational Surrogacy Performed?

In Vitro Fertilization (IVF) is used to obtain the eggs from the Commissioning Couple/Intended Parent, a female partner, or even an egg donor. Sperm from the Commissioning Couple/Intended Parent, or even donor sperm, is then used to fertilize the eggs. The resulting embryos are grown in the lab for a number of days and matured.

What takes place next depends upon the desires of the Commissioning Couple/Intended Parent and the surrogate. It is preferred that a limited number of fresh embryos are transferred using a slender catheter into the surrogate's uterus with the remaining embryos cryopreserved for later use. In this process, the surrogate's uterus must be carefully prepared using injectable hormones such that the uterine lining is synchronized with the person who provided the eggs so that an embryo will successfully implant and grow. Once pregnancy occurs, hormone injections must be continued up through 10-12 weeks gestational age. The greatest advantage of a fresh embryo transfer is the higher pregnancy rates. The biggest disadvantage involves the number of hormone injections. In a fresh transfer, usually two or three embryos are transferred so a multiple pregnancy is also quite possible.

An alternative to the (fresh) embryo transfer is a Frozen Embryo Transfer (FET). If agreed upon by the Commissioning Couple/Intended Parent and the surrogate, all of the embryos originally created are cryopreserved. A limited number are later thawed and carefully transferred into the surrogate's uterus at just the right time to maximize implantation and success. The FET procedure is also commonly performed should the (fresh) embryo transfer not work or if the Commissioning Couple/Intended Parent is seeking to further expand their family with more children after original success.

Technique	Advantages	Disadvantages
Fresh Embryos	➢ Highest pregnancy rates	➢ Slightly higher multiple pregnancy rates ➢ The gestational surrogate has to undergo daily hormone injections prior to embryo transfer and up to 12 weeks gestational age
Frozen Embryos	➢ Transferred during a future natural cycle into the gestational surrogate ➢ Lower multiple pregnancy rates	➢ Lower pregnancy rates ➢ Some embryos may not survive the thaw process

If the embryos are to be frozen, thawed and transferred at a later date, the surrogate need only ovulate at a later time wherein the embryos would be thawed and transferred. While far more convenient for the surrogate, the pregnancy rates are reduced compared to a fresh embryo transfer. Some of the embryos may also not survive the rigors of cryopreservation and thaw. In a frozen embryo transfer, two to four embryos will generally be transferred. Even though more embryos are often transferred in a FET cycle, the multiple pregnancy rates are somewhat lower than with fresh transfers.

Regardless if the embryos are fresh or thawed, the transfer itself is safe, relatively painless and is performed with the utmost care in the ***EDI*** facility. The gestational surrogate will be at bed rest for a short time following the embryo transfer.

If a pregnancy does not occur with the initial transfer, assuming the Gestational Surrogate agrees and there are still some embryos cryopreserved, some of the remaining cryopreserved embryos may be thawed and transferred during a later natural cycle.

How Are The Commissioning Couple/Intended Parent Screened Prior to Gestational Surrogacy?

In Gestational Surrogacy, single embryos are transferred into the surrogate. The potential of transmission of disease is only theoretical because so few cells are transferred. Even understanding this point, the screening of the Commissioning Couple/Intended Parent is designed to offer maximum safety and security to the surrogate. The actual testing will depend somewhat on the makeup of the Commissioning Couple. If they are male/female or male/male, routine labs are obtained on them as listed below. If they are female/donor sperm or male/donor egg, those that donate the sperm/eggs already undergo routine and repeated screening.

Test	Common Name Of The Test	Intended Parent	Partner (when available)
FSH	Follicle Stimulating Hormone	•	
Cystic Fibrosis	Genetic Disease Testing	•	
Genetic	Additional Genetic Testing may be	•	

Testing	requested		
HIV I & II$^{\alpha}$	Human Immunodeficiency Virus	•	•
HTLV 1 & 2	Pending review…	•	•
HBsAg$^{\alpha}$	Hepatitis B Surface Antigen	•	•
HCsAb$^{\alpha}$	Hepatitis C Surface Antibody	•	•
CMV	Cytomegalovirus	•	•
RPR	Syphilis	•	•
GC/Chlam.	Gonorrhea and Chlamydia urine testing	•	•

Except for genetic testing, or otherwise agreed upon, the updating of the above labs is generally done on an annual basis.

What are the Overall Success Rates For Gestational Surrogacy?

A clinical pregnancy means that a positive pregnancy is present as well as a gestational sac identified in the uterus. Clinical pregnancy rates will differ with respect to the age of the women who provides the eggs and the skills of the ART program. It is not uncommon for some of the better programs to achieve a 40-60% clinical pregnancy rate per initiated cycle.

When precise success rates for Gestational Surrogacy are not available, one can review the success rates for egg donation and frozen embryo transfers from egg donation cycles since Gestational Surrogacy is so similar to egg donation in process and success rates. Please ask the staff of EDI to outline their latest statistical success rates.

Spontaneous abortions can still occur and multiple pregnancies are certainly a consideration. The spontaneous pregnancy loss rates are dependent upon the age of the individual who provides the eggs and not the "age" of the uterus. The pregnancy loss rates for women < 35 years old (y.o.) are 10 - 15%, 35 - 40 y.o. are 15 - 20% and > 40 y.o. are generally 40% or more.

The multiple pregnancy rates will vary depending upon a host of factors including the age of the woman producing the eggs, the number of embryos transferred and the skill of the ART team. Once again, please ask for specific data.

Summary Comments:

Surrogacy is an excellent option for many patients. It can be a complicated process, but with very careful attention to detail combined with perseverance and skill, success awaits many who try.