

In-Vitro Fertilization (IVF)

Everything You Want and Need to Know





Support for your growing family

At Northwestern Medicine Fertility and Reproductive Medicine, we are committed to health and wellness for you and your growing family. Thank you for trusting us as your partner in your journey to pregnancy. This booklet will answer many questions you have about in-vitro fertilization (IVF). If you have further questions or concerns, please call our office at 312.695.7269.

How does ovarian stimulation for IVF work?

A woman has a group of antral follicles that she uses or loses every month. Eggs grow inside these follicles, but not every follicle contains an egg. During the natural menstrual cycle, hormones from the brain are released that allow only one follicle in a group of follicles to grow and become the dominant follicle. During ovulation, which is typically monthly, each dominant follicle releases a single egg. The other follicles are lost through a process called atresia.

In an ovarian stimulation cycle for IVF, combinations of reproductive hormones will be given to you in higher doses than what your body naturally produces. This allows for many antral follicles to grow and develop during a single month, so multiple eggs can be rescued and subsequently removed.

Eggs that are removed from the ovary in a single month would otherwise have been lost. Undergoing a single cycle, or even multiple cycles, of IVF does not decrease overall fertility, make you lose your egg supply faster, or cause you to go through menopause earlier.

What do all of the ovarian reserve tests tell me?

Ovarian reserve is an estimate of the remaining supply of eggs in the ovary. Ovarian reserve tests aim to measure both the number of eggs that can be harvested in a single month as well as measure the overall egg supply within the ovary.

Four different tests are often performed together:

- 1 Antral follicle count (AFC).** A measure of the number of resting follicles the ovary contains each month. This is one of the most important tools to predict how many eggs can be retrieved in a single month with the use of fertility drugs.
- 2 Anti-mullerian hormone (AMH).** A hormone produced by the cells that surround each egg in the ovarian follicles. A high AMH indicates a high egg supply, and vice versa. This is one of the most sensitive predictors of the overall egg supply within the ovary.
- 3 Follicle stimulating hormone (FSH).** A hormone released from the brain to stimulate the ovary to grow and ovulate an egg each month. After ovulation, the remaining egg supply in the ovaries sends a signal back to the brain to prevent premature release of additional FSH. FSH then decreases until the next menstrual cycle begins. A high FSH level in the beginning of the menstrual cycle is a sign of low egg supply.
- 4 Day 3 estradiol level.** Estradiol suppresses FSH during the menstrual cycle. Once estradiol begins to increase, FSH stops functioning until the next menstrual cycle. This prevents too many eggs from becoming mature and being ovulated in each menstrual cycle. Estradiol must be checked at the time FSH is checked to ensure that FSH is not falsely low due to suppression.



Infertility is a clinical diagnosis that can only be made in women who have been attempting conception without success for one year prior to age 35 or six months after age 35.

Ovarian reserve screening can indicate egg quantity but cannot predict infertility, nor can it predict the time it would take to achieve pregnancy or the likelihood of success with IVF.

AMH testing can indicate the size of the remaining pool of eggs in the ovary and may be used to help guide decisions about IVF. However, **a low AMH in someone who has never tried to conceive does not indicate infertility.** Table 1 shows the typical values for AMH according to age in the United States. This table can help determine who may have a low egg supply, but this information needs to be used with great caution. There is no long-term data available yet to fully understand the implications of low AMH in young women without infertility.

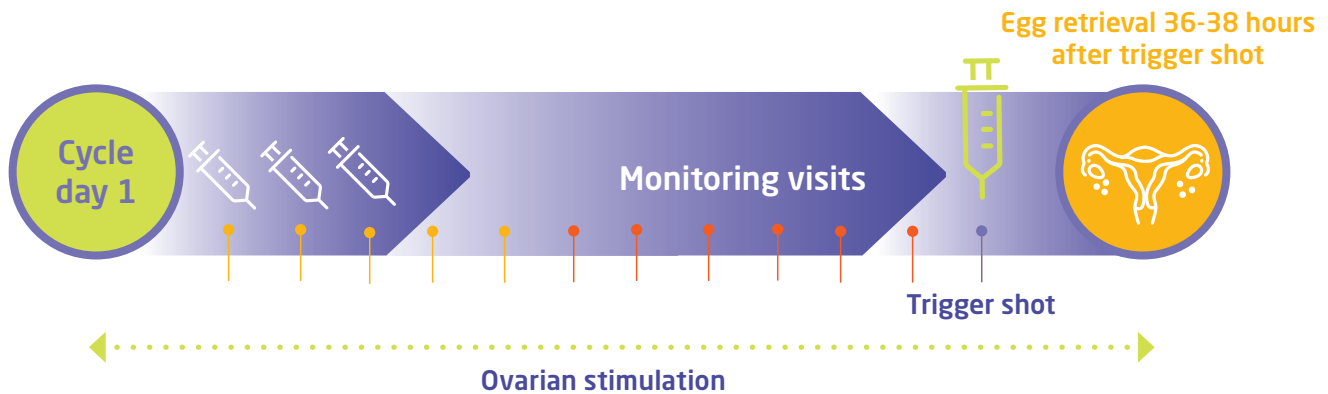
Age	Median AMH
25	3.2
28	2.8
30	2.4
31	2.2
32	1.8
33	1.7
34	1.6
35	1.3
36	1.2
37	1.1
38	0.9
39	0.8
40	0.7
41	0.6
42	0.5
43	0.4

Table 1. Adapted from Siefert, D F&S 2011

What will my schedule look like?

Your physician will establish your individual stimulation protocol based on your age, AMH level, AFC and baseline FSH levels. The IVF process begins with a stimulation cycle, which includes four parts.





Before the stimulation phase, you will come in for a baseline ultrasound and blood work to make sure that your ovaries are ready to begin the process. If you will be taking Lupron, you will begin using it prior to your baseline ultrasound. You should expect a menstrual period after taking Lupron for approximately seven days. Not everyone has bleeding, but many people do.

The baseline ultrasound is performed to make sure that your ovaries are ready to begin the process. It is normal to have a menstrual period during the initial days of stimulation. During the stimulation phase, you will inject yourself with gonadotropins in the thigh or abdomen. The needles are short and small, and we will teach you how to do this safely and easily. You will inject yourself every day, which will encourage your ovaries to allow for multiple follicles to grow and develop.

You will return to the clinic after three days of stimulation meds, on the fourth day of stimulation. You should expect monitoring visits every day or every other day, from day six of stimulation onwards. The stimulation phase typically lasts between eight and 14 days, so most women have eight monitoring visits over a stimulation cycle.

Morning monitoring visits are meant to be quick and efficient. We realize that most of our patients work, and we try to complete your ultrasound and blood work in a timely fashion. If you have an urgent issue and must speak to a nurse during monitoring, please let the ultrasound technician know. Otherwise, you are free to leave after your blood work and ultrasound are complete.

Decisions about your stimulation cycle are made by the physicians once estrogen levels are obtained (usually within a couple hours of your blood being drawn), and a nurse will relay the physician's decision about your cycle to you via a message in NM MyChart. Our preferred method of communicating these results to you is through NM MyChart. Please sign up and activate your account if you have not done so already.

- If estrogen levels are low, resulting in fewer follicles being recruited, you will be asked to raise the dose of medications.
- If levels are high, meaning a high number of follicles are being recruited, you may be asked to lower the dose.
- If levels are appropriate, you will be asked to continue on the same course of medications.

You will be asked to return for more monitoring every one to three days, depending on the progress of your cycle. The decision to trigger is made when the majority of your follicles measure between 16 mm and 22 mm, and your estrogen levels are rising steadily. You will receive a call from our nursing staff on the day you are supposed to take your trigger shot. **The timing of the trigger shot is extremely important**, as your retrieval should be performed 36 to 38 hours after trigger. If you accidentally take your trigger shot more than 30 minutes before or after your assigned time, please notify us the following day.



How will I feel during the stimulation process?

You may feel bloated as your ovaries grow follicles from the stimulation medications. Weight gain of five to six pounds is not unusual and should go away within two weeks after egg retrieval.

You may also feel more emotional due to the hormone changes. Surround yourself with supportive friends and family during this time. Although you should be able to continue working during stimulation, it may be helpful to minimize any work stress to the best of your ability. Try not to make any life-changing decisions while taking hormones. If you are struggling with intense emotions, call your physician. We want to make sure that we take care of all of you—your body and your mind. This can be an intense process, and we have support available.

What activities should I avoid during stimulation?

You should avoid vigorous exercise (running, spinning and other activities that involve bouncing) to minimize the risk of ovarian torsion. Ovarian torsion is a surgical emergency that arises when the ovaries become twisted, reducing their blood supply. If you ever experience a sudden onset of excruciating pain that lasts for more than 15 minutes, call us or go to the nearest emergency department. If you have any pain or concerns at any time, please call 312.695.7269 to reach the physician on call. We carry papers 24/7.

Who will I see during monitoring visits?

Your physician will oversee your cycle from start to finish, but we work together as a team to ensure you are taken care of every step of the way. Morning monitoring visits are handled by ultrasound technicians and the nursing team. These visits are purely for information gathering, and no decisions are made during monitoring. We ask the ultrasound technicians to measure follicles but not to interpret these measurements, as decisions are based upon both ultrasound and estrogen levels. Because technicians are not able to provide a full interpretation of the ultrasound data, please save questions for your nurse.

What will my male partner have to do during the ovarian stimulation phase?

If you are undergoing IVF with a male partner who will be providing fresh sperm on the day of retrieval, he should ejaculate the day prior to trigger or on trigger day. Please remember that you need to avoid vaginal intercourse during IVF stimulation. Your partner should avoid ejaculating on the day after trigger.

What happens on egg retrieval day?

All of the hard work you have done during stimulation is to give yourself the best chance of having a good number of mature eggs. You will be notified on the day of trigger what time to arrive for your egg retrieval. Retrievals are done in the morning or early afternoon, and you are not allowed to eat, drink or chew gum prior to your retrieval. You must bring a responsible adult with you who can drive you home on egg retrieval day.

If you are going through IVF with a male partner who is providing fresh sperm on the day of your retrieval, he can either collect sperm at home and bring it in with you for the retrieval, or he can collect sperm at our IVF center. All sperm collection needs to be done in a sterile cup (or collection condom provided to you by us), and we need the specimen within one hour of collection. Your partner will need to bring a photo ID with him on the day of your retrieval, and he will need to be the one to hand the sperm to the laboratory team for processing.

You will be brought back to the procedure suite inside our Chicago office, given a gown and placed in a bed in preparation for your procedure. A nurse will place an IV in your arm to give you fluids, and you will meet the anesthesiologist and physician who will be doing your procedure. You will be asked to sign a consent form for anesthesia and for egg retrieval. Please let us know if you would like to have your partner or other support person briefly visit with you prior to your procedure, and we can bring that person back to you after your IV has been placed. Your visitor will be escorted out of the procedure suite and to a waiting area once it is time for retrieval.

When it is time for retrieval, an anesthesiologist will provide sedation during your procedure. One of our physicians will perform the procedure, which typically takes about 20 minutes, but you will be in the procedure suite for about two and a half hours. You must have someone present with you to drive you home after the procedure.

Your care plan will be based on your individual response to stimulation. Retrievals can happen any day of the week, and we do not try to schedule them for a particular day or particular physician. We will be ready for your retrieval when your ovaries are ready. This can be on a weekday, weekend or holiday. We do not manipulate your cycle to best fit our schedule.

We are dedicated to giving you the best chance at a successful cycle. To meet this need, we have a comprehensive call schedule among our physicians to ensure that we have a physician available every day of the year, including holidays. The on-call physician will perform your egg retrieval.

After your retrieval is complete, we will let you know how many eggs we were able to retrieve. Not all eggs will be mature, and not all mature eggs will fertilize. On average, about 75 percent of the eggs we retrieve are mature, about 75 percent of those mature eggs fertilize, and 25 to 50 percent of those fertilized eggs form embryos that are suitable for transfer. For example, if we retrieve 10 eggs, eight might be mature, six might fertilize, and two or three might form embryos suitable for transfer.

What if I am freezing my embryos?

If you are freezing all of your embryos, they will either be frozen the day after retrieval at the zygote stage, or five or six days after retrieval at the blastocyst stage. The stage at which your embryos are frozen is determined by your physician and depends on your age, how the stimulation went and multiple other factors.

If you freeze at the zygote stage, the embryologist will call you the day after retrieval to let you know the number of mature eggs, the number of fertilized eggs and the number of zygotes frozen. If you are freezing at the blastocyst stage, you will also get a phone call six days after retrieval to let you know the total number of embryos frozen. The day of retrieval is considered day zero. So if retrieval is on a Monday, you will get a phone call on Sunday.

What problems can arise?

The response to stimulation may not be sufficient.

Your care is individualized based on your age, AMH, AFC and FSH levels. Sometimes we expect to get a lower number of eggs. However, sometimes we do not expect to get a lower number of eggs, and yet we may see a low number of follicles in the setting of a good AMH, young age and favorable pre-cycle testing.

If your AMH is greater than 2.0 and we see fewer than five follicles measuring 15 mm or greater as you approach trigger day, we may discuss the option of cycle cancellation, or conversion to intrauterine insemination. Sometimes, it becomes apparent that a cycle is not progressing appropriately around day six of stimulation, and sometimes this does not become apparent until trigger day. We closely monitor your cycle so that the best decisions regarding your care can be made.

We cancel cycles when we anticipate that you will not have any embryos available for transfer or biopsy for pre-implantation genetic testing. Not every follicle contains an egg, and not every egg fertilizes. Therefore, we may recommend cycle cancellation when there are fewer than three follicles. Sometimes, for reasons we don't always understand, the ovary does not produce as many follicles as it is capable of in a given month. Sometimes this response can be improved during a subsequent month.

The number of eggs retrieved may be lower than anticipated.

While we hope that every follicle contains an egg, sometimes this is not the case. Some women, for reasons that are poorly understood, have empty follicles. The stimulation cycle may look good on ultrasound, but it is not until we actually perform the retrieval and aspirate each follicle from the ovary that we see empty follicles. This is understandably upsetting for both patients and physicians when this happens.

The response to stimulation may be too high.

When too many follicles are produced, you may develop ovarian hyperstimulation syndrome (OHSS). OHSS is an exaggerated response to stimulation that may result in excess fluid in the abdomen after egg retrieval. This happens in about one percent of cases. On rare occasions, you may need to have this fluid drained from your abdomen if symptoms are severe (difficulty breathing, extreme discomfort). Occasionally, cycles can be cancelled before egg retrieval to prevent OHSS, but usually this is something that develops three to seven days after egg retrieval or around the time of a positive pregnancy test.

If your physician is concerned about OHSS, we may recommend proceeding with egg retrieval but freezing all of your embryos to allow your ovaries to rest and your body to recover prior to proceeding with a frozen embryo transfer. We may also alter your trigger shot to decrease the chance of OHSS, or start you on an additional medication at the time of trigger or retrieval.

Other complications are possible.

It is extremely rare for other complications to arise, but as with any surgical procedure, there is a risk of bleeding or infection. If you do not feel well at any time or are concerned, please page the physician on call, who is available 24/7 to address emergencies.

How many eggs should I expect?

The response to stimulation varies. Your AFC has been shown to be the best predictor of the number of eggs that you will produce, but this is just a loose guide. On average, younger patients with higher AMH levels produce more eggs. The average number of eggs produced by women of child-bearing age is 10.

Two types of eggs can be retrieved: immature eggs (these are referred to as GV or MI) and mature eggs (referred to as MII). Only MII eggs can be fertilized.

What happens after egg retrieval?

After the eggs are removed from your ovaries, they are placed in an incubator to allow them to mature further. The eggs are then inseminated with sperm either by conventional insemination, during which a droplet of sperm is placed around the egg, or by intracytoplasmic sperm injection (ICSI), during which a single sperm is injected into the egg.

Decisions regarding the method of fertilization are made by your physician and can be discussed at the IVF registration visit.

ICSI is generally chosen when:

- There is male factor infertility
- An abnormality is found on semen analysis
- Infertility is unexplained
- Patients have chosen pre-implantation (PGS or PGD) testing
- Egg numbers are low
- Patients have chosen medical fertility preservation
- The patient has endometriosis
- Sperm has been frozen

The morning after egg retrieval, the embryologist will assess the number of eggs that have fertilized. Fertilization rates vary based on egg and sperm quality, but the average is around 70 percent. Embryo transfers happen either three days after retrieval or five days after retrieval, and if pre-implantation genetic testing is being performed, embryos are biopsied either five or six days after retrieval.

Will my embryo transfer happen on day three or day five?

The decision of whether to transfer on day three or day five is made by your physician and the embryology team. Day five is used as a method for embryo selection. If we have a lower number of embryos, or if we are able to pick the best embryo(s) for transfer as soon as day two, then a day three transfer will be performed.

Depending on your age, if you have more than three high-quality embryos on day two, and we are unable to choose the one or two best embryos, then the decision is made to do a day five transfer. The number of embryos to transfer is based on your age, your infertility history, and national guidelines meant to optimize success and minimize the risks of multiple gestation.

Your pregnancy test will be done 10 days after a day three transfer, or eight days after a day five transfer.

What should I expect the day of my embryo transfer?

You will get a phone call the day before your embryo transfer letting you know what time to arrive. Embryo transfers are done in the procedure suite in the Chicago office. Unlike egg retrieval, you do not have to have another adult present with you.

It is critical that you arrive with a very full bladder.

We realize this can be quite uncomfortable. However, a full bladder acts as a window in order to best see your uterus. In addition, the uterus straightens out under the pressure of a full bladder, and this makes the transfer easier to perform. Proper visualization and ease of transfer are two of the most important steps in helping your procedure be successful.



After you arrive, you and your partner or support person, if applicable, will be escorted to one of the procedure rooms. You will be asked to undress from the waist down, and you will be given a sheet to place over your lap for coverage.

The procedure room physician will enter the room and will call the embryologist into the room via our phone system. You will be asked to state your name out loud for verification. A second verification will occur when the embryologist enters the room for your transfer. You will be asked to state your full name and date of birth. You will discuss embryo development and the number of embryos to transfer with the physician.

The physician will ask you to lie down and place the back of your knees on the stirrups, and a speculum will be placed inside the vagina to view your cervix. Fluid will be used to clean off the cervix, and this may leak out after transfer.

Transfers are done using ultrasound guidance, and our ultrasound machines are connected to a flat screen TV so that you may be able to watch the procedure. We keep the room dark, as embryos prefer the absence of light, and darkness provides better visibility on the ultrasound. We do not expose the embryos to bright light in the lab, and we do not take photographs of the embryos for this reason.

Embryos are delivered to the uterus through a catheter guided by abdominal or vaginal ultrasound. The embryos stick to the lining of the uterus and do not fall out. The embryologist will check the catheter after transfer is complete to ensure that the embryo(s) did not remain in the catheter. You are free to get dressed, use the restroom (if needed) and leave once we have confirmed the embryo(s) did not remain in the catheter.

Can I freeze surplus embryos?

If you have additional high-quality embryos that have developed to the blastocyst stage, we strongly encourage you to freeze them for possible future use. The advantage of embryo freezing is that you may not have to undergo another egg retrieval in the future. Frozen embryos maintain their quality for at least 10 years and can also help to maximize future success rates by using an embryo that was created from a younger egg.

The freezing process that we use is called vitrification, which is a very safe and highly effective method of embryo freezing. Frozen embryos have the same success rates as fresh embryos, and a frozen embryo can be transferred back to your uterus after a relatively easy preparation phase involving estrogen alone followed by estrogen and progesterone.

Embryos are vitrified on site at Northwestern Medicine Fertility and Reproductive Medicine and are kept in our lab up to two years. Please ask us about longer-term storage options.

Please note, you will have to fill out paperwork prior to embryos being shipped to ReproTech.

What is pre-implantation genetic testing (PGS and PGD)?

Pre-implantation genetic screening or diagnosis (PGS or PGD) can be performed on your embryos either to assess whether all 23 pairs of chromosomes are present (PGS) or to test for a specific disease (PGD), which may be a consideration if you and/or your partner are both known carriers for the same disease, or if one of you is affected by a genetic disease or condition you do not wish to pass on.

PGS and PGD testing is usually not covered by insurance, and costs should be outlined during your IVF registration visit by our financial counselors. There are two separate fees for testing. The fee from our office covers the embryo biopsy and freezing, and the genetic testing company will send a bill for the DNA testing itself. You will be billed for the embryo biopsy and freezing for each cycle you undergo. Depending on the genetic testing company used as well as the type of testing you are doing, charges can be per embryo tested or for testing a predetermined number of embryos. Your physician will recommend which is best for you based on the type of genetic testing you are doing as well as the anticipated numbers of embryos you will produce.

An embryo that is chromosomally normal contains 23 pairs of chromosomes (for a total of 46): 22 pairs of numerical chromosomes (1 - 22) and one pair of sex chromosomes (XX female, XY male). Chromosome screening assesses whether the embryo contains exactly 23 pairs of chromosomes. Embryos that contain either too many or too few chromosomes are considered to be abnormal and are not eligible for embryo transfer. These are called aneuploid embryos.

There are two situations where genetic testing results are not as straightforward:

Not enough DNA for analysis. Sometimes there is not enough DNA within the cells in order to assess the chromosomes. If and when this happens, the Northwestern Medicine embryology team will reassess the physical characteristics to see whether there are enough additional cells in the outer cell layer of the embryo to warm the embryo, perform a second biopsy and refreeze the embryo. The lab will make a recommendation to your physician regarding each embryo that comes back without a clear answer. Your physician will then discuss this recommendation with you and proceed with a mutually agreed upon plan. There is no additional charge to repeat a biopsy and test.

Mosaicism. A biopsy takes four to 10 cells out of the embryo; mosaicism refers to a situation when some of the cells are chromosomally normal and others are not. This is a controversial and evolving area of chromosome screening. If your embryos return as mosaic, you and your physician will have a conversation about how to best proceed.

Embryos are biopsied on day five and day six, and you will get a call from the embryology team on day six to let you know how many embryos were biopsied. All embryos that are suitable for biopsy will be frozen after biopsy. Only embryos that have made it to the blastocyst stage and that have a good number of cells present in the outer (trophectoderm) and inner (inner cell mass) layers will be biopsied. Test results can take seven to 21 days to return, and you will get a call from either your nurse or physician once results have been received.

Only genetically normal embryos will be transferred back to you. **It is critical to understand that genetic testing is 96 percent accurate, not 100 percent, and prenatal testing is still recommended.**



When do I come in for a pregnancy test, and what happens next?

Pregnancy tests are done with a blood draw eight days after day five transfers and 10 days after day three transfers. We discourage the use of home urine pregnancy tests, as they may be inaccurate as a result of the hormones used in your fertility treatment.

The orders will be placed on the day of your embryo transfer, so you do not need to call to schedule an appointment for a blood test at the Chicago office. If you plan to have your blood test at the Highland Park office, please call to make an appointment. If you are a Highland Park patient and your test falls on the weekend, you have the option to be tested in the Chicago office or wait until Monday when you can have your blood drawn in Highland Park.

Pregnancy is measured by the presence of the hormone human chorionic gonadotropin, beta subunit (beta-hCG) in your blood, sometimes just referred to as a beta or hCG. The presence of hCG in your blood indicates that the embryo has implanted into the uterine wall. Early levels of hCG can be an indication that a pregnancy is either progressing normally or abnormally. The initial level of hCG should be greater than 25 mIU/mL, and this level should rise by 66 percent every 48 hours.

If your blood test is negative, you should stop all medications. We do not release pregnancy test results through NM MyChart, so you will get a phone call from one of the nurses. This call will be followed up either by a phone call or office visit with your physician, depending on the complexity of your care. We prefer you schedule an office visit with your physician to discuss the next steps in more complicated situations.

What does it mean if my hCG levels are not rising appropriately?

Insufficient rise in pregnancy hormone levels can indicate a number of possibilities.

Biochemical pregnancy

A biochemical pregnancy is suspected when there is an initial presence of hCG indicating that the embryo has implanted, but hCG levels eventually decline before the gestational sac develops. This type of pregnancy is not visible on ultrasound and is only diagnosed through increasing, then decreasing, hCG levels.

Ectopic pregnancy

An ectopic pregnancy occurs when the embryo implants outside of the uterus, commonly in the fallopian tube, but possibly on an ovary or in the pelvis. Even though the embryo is transferred directly to the uterus, it can still move around and implant outside of the uterus. Ectopic pregnancies are diagnosed by continued rise of hCG levels without visualization of a pregnancy on ultrasound.

By six weeks of gestation, a gestational sac should be visible on ultrasound. If the gestational sac is not visualized, then the diagnosis of biochemical pregnancy, ectopic pregnancy or pregnancy of unknown location is made. Most often, an ectopic pregnancy is strongly suspected due to the abnormal and continued rise of hCG levels.

Ectopic pregnancies are never viable, and they place the pregnant woman's health at risk. Ectopic pregnancies rarely will rupture, but when this happens, they require emergency surgery. One treatment for a confirmed ectopic pregnancy is the administration of an injection of methotrexate that stops the pregnancy from continuing to grow.

It is very important that you are followed closely in early pregnancy, and we often do not advise travel in the first few weeks until we are certain that you do not have an ectopic pregnancy. If you are being treated for an ectopic pregnancy and have sudden onset of severe pain, please call the physician on call and/or go to the emergency department.

Pregnancy of unknown location (PUL)

At times, distinguishing between an ectopic pregnancy and a biochemical pregnancy can be difficult, and further testing is needed. Further testing may include additional blood work or obtaining a tissue sample from the inside of your uterus, either in the office or procedure room. Tissue sampling is only done when your physician is 100 percent certain that the pregnancy is not viable but is not certain whether the embryo implanted inside or outside of the uterus.

If the tissue removal does not cause hCG levels to decrease, or if the pathologist who reviews the tissue sample does not think this is early pregnancy tissue, then the diagnosis of ectopic pregnancy will be made and you may be given methotrexate.

Twin pregnancy/multiple pregnancies

hCG levels may be high, but may not double in pregnancies involving twins or other multiples.

If my hCG levels are normal, how long do I stay on progesterone/estrogen?

Continue estrogen supplementation (for frozen embryo transfers) and progesterone supplementation (for fresh and frozen embryo transfers) until your pregnancy test; if pregnancy is confirmed, continue to your ninth week of pregnancy. Pregnancies are dated such that you are considered to be almost four weeks pregnant at your first blood test.

It is important that you be mindful of how much medication you have at home and how much more you need to order. The medications have been prescribed with refills, so you just need to call your pharmacy to order a refill. You should not need a new prescription.

When do I return to my OB/GYN?

You will be followed by our team until you are approximately eight or nine weeks pregnant. Once your pregnancy has been confirmed by ultrasound, please call your OB/GYN to make an appointment for a new OB visit. These appointments can be difficult to schedule, so it is best to call early in your pregnancy. OB/GYN specialists generally schedule the new OB visit anywhere between nine and 11 weeks of pregnancy.

If you do not have an OB/GYN specialist, please let us know and we will happily recommend one, or visit nm.org and use the Find a Doctor feature to select a specialist near you. Many great practices are affiliated with Northwestern Medicine and Prentice Women's Hospital, including Northwestern Memorial Hospital and Northwestern Medicine Lake Forest Hospital.

Thank you for letting our family help build your family. If you have any questions or concerns, or would like to schedule an appointment with a physician at Northwestern Medicine Fertility and Reproductive Medicine, call 312.695.7269. You may also visit us online at fertility.nm.org.



Northwestern Medicine
Fertility and Reproductive Medicine Chicago
259 East Erie Street, Suite 2400
Chicago, Illinois 60611
312.695.7269

Northwestern Medicine
Fertility and Reproductive Medicine Highland Park
600 Central Avenue, Suite 333
Highland Park, Illinois 60035
847.535.8700

Northwestern Medicine
Fertility and Reproductive Medicine Oakbrook Terrace
2 Trans Am Plaza, Suite 400
Oakbrook Terrace, Illinois 60181
630.545.3766

TTY for the hearing impaired: 312.926.6363

fertility.nm.org