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Female and Male Infertility
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Patient ID # _____

YOUR TREATMENT PLAN -

NAME: _____ DATE: _____

<p><u>First Cycle</u></p> <ul style="list-style-type: none">○ Natural cycle○ Letrozole or Clomid Ovulation Induction○ FSH Inject Ovulation Induction○ Intrauterine Insemination IUI○ IVF	<p><u>Notes/Instructions/Dosage</u></p> <p>CLOMID- Side Effects- headaches, irritable & sleep disturbance.</p> <p>DAY 1- Period. Call clinic to book Ultrasound for Day 11, 12 or 13</p> <p>DAY 5 to 9- Clomid 50mg (5 days)</p> <p>DAY 9- Stop Intercourse</p> <p>DAY 11, 12 or 13- Ultrasound</p>
<p><u>Second Cycle</u></p> <ul style="list-style-type: none">○ Natural cycle○ Letrozole or Clomid Ovulation Induction○ FSH Inject Ovulation Induction○ Intrauterine Insemination IUI○ IVF	<p><u>Notes/Instructions/Dosage</u></p>
<p><u>Third Cycle</u></p> <ul style="list-style-type: none">○ Natural cycle○ Letrozole or Clomid Ovulation Induction○ FSH Inject Ovulation Induction○ Intrauterine Insemination IUI○ IVF○ Surgery	<p><u>Notes/Instructions/Dosage</u></p>