

Recommendations for practices utilizing gestational carriers: an ASRM Practice Committee guideline

The Practice Committee of the American Society for Reproductive Medicine and the Practice Committee for the Society for Assisted Reproductive Technology

American Society for Reproductive Medicine; and Society for Assisted Reproductive Technology, Birmingham, Alabama

This document provides the latest recommendations for evaluation of gestational carriers and intended parents. It incorporates recent information from the US Centers for Disease Control and Prevention, the US Food and Drug Administration, and the American Association of Tissue Banks, with which all programs offering gestational carrier services must be thoroughly familiar. (Fertil Steril® 2012; ■: ■-■. ©2012 by American Society for Reproductive Medicine.)

Earn CME credit for this document at www.asrm.org/eLearn

STATEMENT OF PURPOSE

The following recommendations are intended to provide guidance for when it is appropriate to consider using a gestational carrier, provide guidelines for screening and testing of genetic parents and gestational carriers to reduce the possibility of complications, and to address the complex medical and psychological issues that confront the gestational carrier and the intended parents, as well as the children. These guidelines incorporate recent information about optimal screening and testing for sexually transmitted infections (STI) and psychological assessments. The current document represents an effort to make the screening guidelines for individuals involved in third-party reproduction using a gestational carrier more consistent and incorporates recent information from the US Centers for Disease Control and Prevention (CDC), US Food and Drug Administration (FDA), and American Association of Tissue Banks (AATB).

These guidelines use terminology from the federal agencies in addition to the AATB. In that context, the term “screening” refers to specific historical

factors that place an individual at a higher risk for a given disease, such as human immunodeficiency virus (HIV) and transmissible spongiform encephalopathy (TSE), or Creutzfeldt-Jakob disease (CJD). “Testing” refers to specific laboratory studies such as serologic tests. The distinction between screening and testing is consistent within the document. The term “ineligible” does not mean excluded, but eligible with appropriate informed consent.

These guidelines for the screening and testing of gestational carriers and the genetic parents apply to individuals in the United States. Because the prevalence of STIs and genetic diseases may vary in other geographic areas, these guidelines may not be appropriate for other countries or individuals who come to the United States from other countries. Whereas the FDA does not require screening or testing of the gestational carrier, the American Society for Reproductive Medicine (ASRM) recommends testing these individuals as described. Other areas where the ASRM recommendations may be more stringent than the FDA minimum requirements are noted in the text. Additionally, state requirements may be more restrictive

than the FDA, and clinics should be aware of minimum screening and testing requirements for their state.

1. Indications for the use of a gestational carrier:
 - a. Gestational carriers may be used when a true medical condition precludes the intended parent from carrying a pregnancy or would pose a significant risk of death or harm to the woman or the fetus. The indication must be clearly documented in the patient’s medical record. Examples of such medical indications would include:
 - i. Absence of uterus (congenital or acquired)
 - ii. Significant uterine anomaly (e.g., irreparable Asherman syndrome; unicornuate uterus associated with recurrent pregnancy loss)
 - iii. Absolute medical contraindication to pregnancy (e.g., pulmonary hypertension)
 - iv. Serious medical condition that could be exacerbated by pregnancy or cause significant risk to the fetus
 - v. Biologic inability to conceive or bear a child, such as single male or homosexual male couple.
 - b. Gestational carriers may be considered when an unidentified endometrial factor exists, such as

Received March 8, 2012; accepted March 9, 2012.

Reprint requests: American Society for Reproductive Medicine, Education, 1209 Montgomery Highway, Birmingham, AL 35216 (E-mail: asrm@asrm.org).

Fertility and Sterility® Vol. ■, No. ■, ■ 2012 0015-0282/\$36.00
Copyright ©2012 American Society for Reproductive Medicine, Published by Elsevier Inc.
doi:10.1016/j.fertnstert.2012.03.011

for patients with multiple unexplained previous IVF failures despite transfer of good-quality embryos.

- c. No owner, operator, laboratory director, or employee of the practice may serve as a carrier or intended parent in that practice.
2. Intended parents:
 - a. Psychosocial education

The decision to use a gestational carrier is complex, and patients and their partners (if applicable) may benefit from psychosocial education to aid in this decision. The physician should strongly recommend psychosocial education and counseling by a qualified mental health professional to all intended parents. The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological test data should be handled in accordance with American Psychological Association Ethical Standards (1). The physician should require psychological consultation for couples in whom factors appear to warrant further evaluation. The potential impact of the relationship between the intended parent and carrier should be explored, as should any plans that may exist relating to disclosure and future contact (see section titled Psychosocial consultation for gestational carriers and intended parents 4.a.).
 - b. Screening and testing of genetic parents
 - i. Genetic parents should undergo appropriate genetic evaluation based on history, in accordance with ethnic background and current guidelines. Cystic fibrosis testing should be performed on all genetic parents.
 - ii. The genetic parents should undergo a complete medical evaluation including a thorough history and physical examination to ensure that they are healthy enough to proceed with procedures involving assisted reproduction technologies (ART).
 - iii. Genetic parents must be screened in the same manner as gamete donors (2–4). Prospective genetic parents with any identified risk factors based on screening questionnaires are considered ineligible according to guidelines issued by the FDA. According to current FDA guidelines, embryos created by such individuals can still be transferred into a gestational carrier provided that the tissue is labeled to indicate any associated increased risks and that physicians transferring the embryos are aware of the status of the results. Although the FDA does not require that the gestational carrier be informed of the results of the screening, ASRM recommends that embryos created using gametes from individuals considered ineligible should only be transferred to a gestational carrier who is adequately informed and counseled regarding the associated potential risks.
 - iv. Before acceptance, and within 6 months of creating the embryos to be transferred, the genetic parents must undergo a complete physical examination (Society for Assisted Reproductive

Technology [SART] physical examination forms, www.sart.org). When any of the following is present, the genetic parents are considered ineligible (see above).

1. Physical evidence for risk of sexually transmitted disease, such as genital ulcerative lesions, herpes simplex, chancroid, and urethral discharge
 2. Physical evidence of risk for syphilis or evidence of syphilis
 3. Physical evidence of anal intercourse in the male partner, including perianal condylomata
 4. Physical evidence of nonmedical percutaneous drug use, such as needle tracks; the examination should include examination of tattoos, which might obscure needle tracks
 5. Physical evidence of recent tattooing, ear piercing, or body piercing (within the past 12 months) where sterile technique was not used
 6. Disseminated lymphadenopathy
 7. Unexplained oral thrush
 8. Blue or purple spots consistent with Kaposi sarcoma
 9. Unexplained jaundice, hepatomegaly, or icterus
 10. Large scab consistent with recent history of smallpox immunization
 11. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinal keratitis)
- v. Laboratory testing

There is no method that completely ensures that infectious agents will not be transmitted to the gestational carrier. However, the following guidelines, combined with an adequate medical history and specific exclusion of individuals at high risk for HIV and other STIs should significantly reduce these risks. The FDA requires that the following tests be performed within 30 days of oocyte retrieval and within 7 days of sperm collection, using methods approved specifically for purposes of determining donor eligibility, and that negative results be documented before use of the genetic parent's gametes. Tests using nucleic acid testing (NAT) technology to target sequences located in specific genes adequately and appropriately reduce the risk of transmission of these relevant communicable agents. The list of test methods approved by the FDA for the purpose of donor screening is available at the following Web sites: <http://www.fda.gov/cber/products/testkits.htm>, <http://www.fda.gov/cber/tissue/prod.htm>

 1. HIV-1 antibody and NAT
 2. HIV-2 antibody
 3. HIV group O antibody. Establishments that do not use an FDA-licensed test for HIV

- group O antibodies must evaluate the genetic parents for risk associated with HIV group O infection with additional screening questions (see “risk factor questionnaire for donors,” available at www.sart.org)
4. Hepatitis C antibody and NAT
 5. Hepatitis B surface antigen
 6. Hepatitis B core antibody (IgG and IgM)
 7. Serologic test for syphilis
 8. Additional testing for the female genetic parent must include:
 - a. *Neisseria gonorrhoea* and *Chlamydia trachomatis* NAT on urine or a swab obtained from the cervix, urethral meatus, or vagina. Because there are no tests licensed, approved, or cleared by the FDA for screening donors for *Neisseria gonorrhoea* and *Chlamydia trachomatis*, the laboratory must use an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population
 9. Additional testing for the male genetic parent must include:
 - a. *Neisseria gonorrhoea* and *Chlamydia trachomatis* testing using a NAT on urine or a swab obtained from the urethral meatus using an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population
 - b. HTLV-1 and HTLV-2
 - c. Cytomegalovirus (CMV) (IgG and IgM)
 10. ASRM recommends testing the genetic parents' blood type and Rh factor. If there is the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.
- vi. Managing laboratory results
1. A positive test should be confirmed before notifying the potential genetic parent. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
 2. Individuals with false-positive test results for syphilis using non-treponemal assays that are confirmed to be negative using a treponemal-based assay are considered eligible.
 3. Individuals with positive tests for syphilis, *Neisseria gonorrhoea*, or *Chlamydia trachomatis* should be treated, retested, and deferred from creating embryos for use in a gestational carrier for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented documenting successful treatment more than 12 months prior, no further deferral is needed as long as current testing does not indicate an active infection.
 4. Men who test positive for active CMV infection (positive urine or throat culture or paired serum samples demonstrating a fourfold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded until signs of active infection are no longer present. There are many strains of CMV, and superinfection in the gestational carrier is possible even if she is CMV IgG positive. The risk of CMV transmission and newborn CMV infection from an embryo transfer is extremely low, and such infants appear to have no significant illness or other abnormality.
5. Individuals who initially test positive (except for treated syphilis, *Neisseria gonorrhoea*, *Chlamydia trachomatis*, or CMV as described above) are considered ineligible. According to current FDA guidelines, embryos created by such individuals can still be transferred into a gestational carrier provided that the tissue is labeled to indicate any associated increased risks and that physicians transferring the embryos are aware of the status of the results. Although the FDA does not require that recipients be informed of the test results, in the opinion of the ASRM, recipients must be informed and counseled appropriately before such embryos can be transferred into a gestational carrier.
- vii. Quarantining of embryos
- All potential gestational carriers should be offered the option of cryopreserving and quarantining embryos derived from the genetic parents for 180 days, with release of embryos only after the genetic parents have been retested with confirmed negative results (see section on laboratory testing for intended parents, 2.v.1-9.). However, couples also should be informed that embryo cryopreservation may significantly reduce implantation rates. The gestational carrier should be counseled appropriately in the event of seroconversion of a genetic parent after cryopreservation of the embryos.
- viii. Record keeping
- The FDA requires that records pertaining to each genetic parent (screening and test results) be maintained for at least 10 years. However, in the opinion of the ASRM, a permanent record of each intended parent's initial screening, testing, and subsequent follow-up evaluations should be maintained. To the extent possible, the clinical outcome for each cycle should be recorded. A mechanism must exist to maintain such records as a future medical resource for any offspring produced.
1. Protection of confidentiality: Individuals participating in gestational carrier programs should be assured that their confidentiality and medical information will be protected insofar as federal and local statutes permit.

Medical records detailing the eligibility of the intended parents should be maintained as stipulated by federal and local requirements.

- ix. Legal issues and informed consent
 1. The genetic parents should be counseled regarding the risks and adverse effects of ovarian stimulation and retrieval, with such counseling documented in the patients' permanent medical records.
 2. Intended parents must have ongoing legal counsel by an appropriately qualified legal practitioner who is experienced with third-party reproduction and licensed to practice in the relevant state or states, or in the event of an international arrangement, in addition to any relevant states, the intended parent(s)' home country.
3. Gestational carriers
 - a. Selection and evaluation of gestational carriers:
 - i. Psychosocial evaluation and counseling by a qualified mental health professional is strongly recommended for all potential gestational carriers and their partners. The assessment should include a clinical interview and, where appropriate, psychological testing. Psychological test data should be handled in accordance with American Psychological Association Ethical Standards (1). The physician should require psychological consultation for couples in whom factors appear to warrant further evaluation. The potential impact of the relationship between the gestational carrier and intended parent should be explored, as well as any plans that may exist relating to disclosure and future contact (see section on laboratory testing for intended parents, 4.a.).
 1. The psychosocial evaluation and counseling should consider the impact of the pregnancy on family and community dynamics.
 2. Carriers must be of legal age, and preferably between the ages of 21 and 45 years. Certain situations may dictate the use of a carrier older than 45 years of age, but all parties involved must be informed about the potential risks of pregnancy with advancing maternal age.
 3. Ideally, the carrier should have had at least one, term, uncomplicated pregnancy before being considered as a gestational carrier for another couple.
 4. Ideally, the carrier should not have had more than a total of five previous deliveries or three deliveries via cesarean section.
 5. Ideally, the carrier should have a stable family environment with adequate support to help her cope with the added stress of pregnancy.
 - b. Screening and testing of a gestational carrier
 - i. A complete personal and sexual history should be obtained to identify individuals who might be at high risk for HIV, STIs, or other infections that

might be transmissible to the fetus. Although the FDA does not require screening or testing of gestational carriers for possible transmissible infectious diseases to the fetus, ASRM recommends testing of all gestational carriers and their partners within 30 days before embryo transfer to protect the health and interests of all parties involved (see www.sart.org for screening questionnaire).

- ii. Before acceptance, the potential gestational carrier should undergo a complete medical evaluation by a qualified medical professional and be cleared for pregnancy before being considered.
- iii. The carrier should not be used when any of the following findings are present:
 1. Physical evidence for risk of sexually transmitted disease, such as genital ulcerative lesions, herpes simplex, chancroid, and urethral discharge
 2. Physical evidence of risk for syphilis or evidence of syphilis
 3. Physical evidence of nonmedical percutaneous drug use, such as needle tracks; the examination should include examination of tattoos, which might obscure needle tracks
 4. Physical evidence of recent tattooing, ear piercing, or body piercing (within the past 12 months) where sterile technique was not used
 5. Disseminated lymphadenopathy
 6. Unexplained oral thrush
 7. Blue or purple spots consistent with Kaposi sarcoma
 8. Unexplained jaundice, hepatomegaly, or icterus
 9. Large scab consistent with recent history of smallpox immunization
 10. Eczema vaccinatum, generalized vesicular rash, severely necrotic lesion (consistent with vaccinia necrosum), or corneal scarring (consistent with vaccinia keratitis)
- iv. Laboratory testing

There is no method to completely ensure that the carrier will not have infectious agents that could be transmitted to the fetus. However, the following guidelines, combined with an adequate medical history and specific exclusion of individuals at high risk for HIV and other STIs, should dramatically reduce these risks. The ASRM recommends the following tests be performed on the carrier and her partner and that negative results be documented before use of the gestational carrier.

 1. HIV-1 antibody as well as NAT
 2. HIV-2 antibody
 3. HIV group O antibody
 4. Hepatitis C antibody and NAT
 5. Hepatitis B surface antigen

6. Hepatitis B core antibody (IgG and IgM)
7. Serologic test for syphilis
8. CMV (IgG and IgM)
9. For women:
 - a. *Neisseria gonorrhoea* and *Chlamydia trachomatis* testing using cervical cultures or NAT on urine or a swab obtained from the cervix, vagina, or urethral meatus using an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population
 - b. Blood type and Rh factor. If there is the potential for Rh incompatibility, couples should be informed about the obstetric significance of this condition.
 - c. Papanicolaou smear
 - d. Mammogram according to American College of Obstetricians and Gynecologists guidelines
 - e. Titers for varicella and rubella
 - f. Urine drug screen
10. Additional testing for the male partner should include:
 - a. *Neisseria gonorrhoea* and *Chlamydia trachomatis* testing using a NAT on urine or a swab obtained from the urethral meatus using an FDA-licensed, -approved, or -cleared test labeled for the detection of these organisms in an asymptomatic, low-prevalence population
 - b. HTLV-1 and HTLV-2
 - c. CMV (IgG and IgM)
- v. Managing laboratory results
 1. A positive test should be confirmed before notifying the individual. If a test is confirmed positive, the individual should be referred for appropriate counseling and management.
 2. Individuals who test positive for HIV-1, HIV-2, HIV group O antibody, hepatitis B, or hepatitis C should generally not be allowed to serve as gestational carriers. Exceptions to this recommendation require careful counseling, informed consent, and documentation of risks in the medical records.
 3. Individuals found to be positive for syphilis, *Neisseria gonorrhoea*, or *Chlamydia trachomatis* should be treated, retested, and deferred from use as a gestational carrier for 12 months after documentation that treatment was successful before being reconsidered. If evidence is presented documenting successful treatment more than 12 months prior, no further deferral is needed as long as current testing does not indicate an active infection.
 4. Individuals with false positive results for syphilis using non-treponemal assays that are confirmed to be negative using a treponemal-based assay are eligible to be used as gestational carriers.
5. Women or their partners who test positive for active infection with CMV (positive urine or throat culture or paired serum samples demonstrating a four-fold rise in IgG antibody and IgM antibody at least 30% of the IgG level) should be excluded from serving as a carrier until signs of active infection are no longer present.
- vi. Legal issues and informed consent
 1. Gestational carriers and their partners/spouse should be advised explicitly of the risks of the procedures and medications as well as potential complications of pregnancy, including the possibility of prolonged bed rest or hospitalization. This counseling should be documented in the patients' permanent medical record.
 2. Gestational carriers must have ongoing independent legal representation by an appropriately qualified legal practitioner who is experienced with gestational carrier contracts and who is licensed in the relevant state or states, or in the event of an international arrangement, in addition to any relevant states, the intended parent(s)' home country.
 3. Special consideration should be given to transferring a single embryo in an effort to limit the risks of multiple pregnancy for the carrier. After appropriate counseling and agreement by all parties, additional embryos may be transferred based on the age of the genetic parent, in an effort to improve the probability of pregnancy.
 4. Protection of confidentiality: Individuals participating in gestational carrier programs should be assured that their confidentiality and medical/psychological information will be protected insofar as federal and local statutes permit.
 5. Issues regarding screening and testing of the fetus during pregnancy should be discussed and the discussion documented in the medical record or legal contract between the carrier and the intended parents. Contingency plans for management of specific complications (i.e., abnormal genetic testing of the fetus, birth defects, etc.) should be discussed and agreed upon in advance of treatment. The possibility of pregnancy termination for pregnancy complications (in the gestational carrier or fetus) or for multifetal gestations also should be discussed before treatment.
 6. Behavior of the gestational carrier: Individuals who smoke, consume alcohol (>1 drink per day) or have other potentially harmful habits should not be considered as gestational carriers. Activity of the carrier (travel, exercise, diet, vitamin supplements, etc.) should

be discussed between the parties and agreed upon in advance of treatment.

7. Compensation to the gestational carrier: Compensation to the gestational carrier should be agreed upon in writing in the legal contract between the intended parents and carrier before any treatment begins. The amount of compensation paid to the carrier can be prorated based on the procedure(s) performed.
- vii. Quarantining of embryos

All potential gestational carriers should be offered the option of cryopreserving and quarantining embryos derived from the intended parents for 6 months, with release of embryos only after the intended parents have been retested with confirmed negative results (see section on laboratory testing of gestational carriers 3.iv.1-10.). In the event of seroconversion of an intended parent after cryopreservation of the embryos, the ASRM recommends that the embryos should not be transferred into a gestational carrier.
- viii. Record keeping

A permanent record of each gestational carrier's initial selection process, medical evaluation, eligibility, and subsequent follow-up evaluations should be maintained indefinitely. The clinical outcome for each cycle should be recorded. A mechanism must exist to maintain such records as a future medical resource for any offspring produced.
4. Psychosocial consultation for gestational carriers and intended parents
 - a. Psychosocial consultation for intended parents includes:
 - i. A clinical interview and psychological assessment including the intended parent(s)' history of infertility and methods of coping
 - ii. Psychological evaluation of each intended parent is strongly recommended as a means to alert the team to significant psychological issues that could compromise successful collaboration with the gestational carrier
 - iii. Informing intended parent(s) of potential psychological issues and risks associated with the gestational carrier process
 - iv. Discussion of the medical protocol, scheduling demands, risks of cancelled cycles or unsuccessful cycles, number of embryos transferred, multiple pregnancy, multifetal pregnancy reduction, prenatal diagnostic testing, and elective termination
 - v. Requirement of intended parent(s)' agreement with the gestational carrier regarding all medical issues
 - vi. Definition of role/function of qualified mental health professional
 - vii. Counseling topics include:
 1. Management during pregnancy of expectations and relationship with the gestational carrier and her family
 2. Meeting the emotional and physical needs of the gestational carrier and her family
 3. Understanding the gestational carrier's right to make choices for her body over the rights of the intended parents
 4. Rights of the gestational carrier to refuse or to accept medical interventions or testing
 5. Number of embryos to be transferred and number of cycles planned to be determined by the gestational carrier and physician
 6. Multiple pregnancy and associated risks
 7. Multifetal pregnancy reduction and discussion of psychological risks and concerns
 8. Possibility of abortion in the event of an abnormal fetus
 9. Gestational carrier's behavior during pregnancy and methods for resolving conflicts (e.g., eating habits, prescription drugs, alcohol)
 10. Disclosure to offspring
 11. Disclosure to family members and friends
 12. Expectations of relationship between gestational carrier, intended parent(s), and children after birth
 13. Need for gestational carrier and her children to interact with baby after birth
 14. Disposition of extra embryos
 15. Need for separate legal consultation and a written contract
 16. Potential guilt reaction of gestational carrier associated with failed attempts or problem that may arise
 17. Matching of gestational carrier and intended parent(s)
 18. Relationship issues, expectations, and impact of failed cycle
 - b. Criteria for rejection of intended parents
 - i. Absolute criteria for rejection include:
 1. Inability to maintain respectful and caring relationship with gestational carrier
 2. Abnormal psychological evaluation as determined by the qualified mental health professional
 3. Unresolved or untreated addiction, child abuse, sexual or physical abuse, depression, eating disorder
 4. Unresolved or untreated major depression, bipolar disorder, psychosis, or significant anxiety disorder or personality disorder
 5. Current marital or relationship instability
 6. Intended parent(s)' failure to agree with gestational carrier's decision on number of embryos transferred
 - ii. Relative criteria for rejection include:
 1. Ongoing legal disputes
 2. Significant and ongoing problematic interpersonal relationships

3. History of noncompliance or ongoing problematic interactions with program or medical staff
- c. Psychosocial consultation for gestational carriers includes:
 - i. Informing the potential gestational carrier and her partner regarding the potential psychological issues and risks associated with the process
 - ii. Discussion of the medical protocol, including scheduling demands, risks of cancelled cycle and unsuccessful cycle, multiple pregnancy, multifetal pregnancy reduction, prenatal diagnostic testing, and elective termination
 - iii. Discussion of requirement of intended parent(s)' agreement with gestational carrier regarding all medical issues
 - iv. Definition of role/function of the qualified mental health professional
 - v. Counseling topics include:
 1. Management of the relationship between the intended parent(s) and the gestational carrier; past, present, and future
 2. Coping appropriately with the pregnancy
 3. Risks of attachment to the child and risk to the gestational carrier's children
 4. Impact on gestational carrier's marriage or partnership
 5. Impact on gestational carrier's employment
 6. The balance between the gestational carrier's right to privacy and the intended parent(s)' right to information
 - vi. Offer of group/individual counseling with qualified mental health professional
 - vii. Separate, ongoing legal counsel and representation for gestational carrier and intended parents
 - viii. Informing the gestational carrier of source of gametes before legal consent
 - ix. Social history, including family of origin
 - x. Psychiatric history including prior hospitalizations, suicide attempts, medication, and counseling
 - xi. Occupational and financial history
 - xii. Sexual and reproductive history
 - xiii. History of smoking, substance use, and physical, emotional, or sexual abuse
 - xiv. History of postpartum disorder(s) and other unresolved negative reproductive events
 - xv. Religious beliefs that may influence behavior
 - xvi. Maturity, judgment, assertiveness, and decision-making skills
 - xvii. Legal history
 - xviii. Negative medical history as it relates to the psychosocial adjustment of being a gestational carrier (e.g., bed rest, gestational diabetes, preeclampsia)
 - xix. Personality style and coping skills, capacity for empathy
 - xx. Current major life stressors or anticipated changes within the next 2 years
 - xxi. Previous gestational carrier experience or application to another facility
 - xxii. Motivation to become a gestational carrier
 - xxiii. Support of significant other
 - xxiv. Social network
 - xxv. Desire for more children of her own
 - xxvi. Anticipated impact of gestational experience upon her children and significant other
 - xxvii. Anticipated type and duration of relationship with intended parents
 - xxviii. Ability to separate from and relinquish the child
 - xxix. Anticipated feelings toward the child
 - xxx. Feelings about multiple pregnancy, bed rest, hospitalization, and pregnancy loss
 - xxxi. Feelings about possible sexual abstinence
 - xxxii. Feelings and decisions about termination of pregnancy, multifetal pregnancy reduction, amniocentesis, chorionic villi sampling, and other prenatal diagnostic testing
 - xxxiii. Reactions to the possibility of becoming infertile as a result of the process
 - xxxiv. Agreement with the financial compensation arrangement
- d. Criteria for rejection of a gestational carrier
 - i. Absolute rejection criteria include:
 1. Cognitive or emotional inability to comply or consent
 2. Evidence of financial or emotional coercion
 3. Abnormal psychological evaluation/testing as determined by the qualified mental health professional
 4. Unresolved or untreated addiction, child abuse, sexual abuse, physical abuse, depression, eating disorders, or traumatic pregnancy, labor and/or delivery
 5. History of major depression, bipolar disorder, psychosis, or a significant anxiety disorder
 6. Current marital or relationship instability
 7. Chaotic lifestyle, current major life stressor(s)
 8. Inability to maintain respectful and caring relationship with intended parent(s)
 9. Evidence of emotional inability to separate from/surrender the child at birth
 - ii. Relative rejection criteria include:
 1. Failure to exhibit altruistic commitment to become a gestational carrier
 2. Problematic personality disorder
 3. Insufficient emotional support from partner/spouse or support system
 4. Excessively stressful family demands
 5. History of conflict with authority
 6. Inability to perceive and understand the perspective of others
 7. Motivation to use compensation to solve own infertility
 8. Unresolved issues with a negative reproductive event

Acknowledgments: This report was developed under the direction of the Practice Committee of the American Society for Reproductive Medicine (ASRM) in collaboration with the Society for Assisted Reproductive Technology (SART) as a service to its members and other practicing clinicians. Although this document reflects appropriate management of a problem encountered in the practice of reproductive medicine, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment. Other plans of management may be appropriate, taking into account the needs of the individual patient, available resources, and institutional or clinical practice limitations. The Practice Committees and the Board of Directors of ASRM and SART have approved this report.

This document was reviewed by ASRM members and their input was considered in the preparation of the final document. The following members of the ASRM Practice Committee participated in the development of this document. All Committee members disclosed commercial and financial relationships with manufacturers or distributors of goods or services used to treat patients. Members of the Committee who were found to have conflicts of interest based on the relationships disclosed did not participate in the discussion or development of this document.

Samantha Pfeifer, M.D.; Marc Fritz, M.D.; Jeffrey Goldberg, M.D.; R. Dale McClure, M.D.; Roger Lobo, M.D.; Michael Thomas, M.D.; Eric Widra, M.D.; Mark Licht, M.D.; Glenn Schattman, M.D.; Mark Licht, M.D.; John Collins, M.D.; Marcelle Cedars, M.D.; Catherine Racowsky, Ph.D.; Michael Vernon, Ph.D.; Owen Davis, M.D.; Kurt Barnhart, M.D.; Clarisa Gracia, M.D., M.S.C.E.; Kim Thornton, M.D.; William Catherino, M.D., Ph.D.; Robert Rebar, M.D.; Andrew La Barbera, Ph.D.

REFERENCES

1. American Psychological Association. Ethical principles of psychologists and code of conduct. Available at: <http://www.apa.org/ethics/code/index.aspx>. Accessed November 22, 2011.
2. Practice Committee of American Society for Reproductive Medicine, Practice Committee of Society for Assisted Reproductive Technology. 2008 Guidelines for gamete and embryo donation: a Practice Committee report. *Fertil Steril* 2008;90(5 Suppl):S30–44.
3. Society for Assisted Reproductive Technology. Female donor physical examination form. Available at: <http://www.sart.org/login/>. Accessed February 8, 2012.
4. Society for Assisted Reproductive Technologies. Male donor physical examination form. Available at: <http://www.sart.org/login/>. Accessed February 8, 2012.

1 Recommendations for practices utilizing gestational carriers: an ASRM Practice Committee guideline

The Practice Committee of the American Society for Reproductive Medicine and the Practice Committee for the Society for Assisted Reproductive Technology
Birmingham, Alabama

This document provides the latest recommendations for the use of a gestational carrier, including indications for this technique and the evaluation of carriers and intended parents.