learning about fertility preservation, we coded interviews as either “Oncologist-Initiated” or “Patient-Initiated.” During their interviews, respondents who had discussed fertility preservation with their oncologist were asked who brought up the topic. Respondents were also asked if they discussed the issue with any other healthcare workers, such as nurses, before starting cancer treatment. The vast majority did not. In a couple cases, the issue was brought up by another healthcare worker (e.g., a breast surgeon), which then prompted the patient to approach her oncologist. Respondents who initiated the conversation were categorized in Trajectories 4 or 5; those who indicated that their oncologist started the conversation were categorized in Trajectories 2 or 3.

Stage 3: Were fertility preservation options discussed?
Throughout the coding of Stages 1 and 2, it was evident that fertility preservation options were not routinely discussed even if fertility impairment was. Therefore, we further coded interviews where fertility was discussed into two categories—“Options Discussed” and “Options Not Discussed.” We defined fertility preservation treatment options as procedures performed prior to radiation and chemotherapy, where the goal is to preserve fertility functioning; procedures included standard options (e.g., oocyte/embryo freezing) as well as investigational options (e.g., ovarian cryopreservation; see [2] for further discussion.) “Options Discussed” included situations where respondents recalled their oncologist discussing some range of fertility-preserving options and/or referred the respondent to a fertility specialist prior to treatment to explore available procedures. “Options Not Discussed” included experiences where a respondent did not remember being told about any fertility-preserving options, was not sent to a fertility specialist prior to the start of her treatment, and/or was told not to worry about the