Genetic Amniocentesis Consent

1. The purpose of Amniocentesis is to detect certain birth defects, including most fetal chromosome disorders and neural tube defects. My reason for having amniocentesis is _____ .
2. Before the Amniocentesis I will have an ultrasound to help locate the placenta and fetus. Ultrasound may also detect twins, incorrect dating of the pregnancy, and some, but not all, physical defects in the fetus.
3. Amniocentesis involves inserting a needle through the woman's abdomen into the fluid in her uterus. A small amount of fluid (less than 1 ounce) is taken out. There may be some discomfort when the needle is inserted.
4. There are serious complications in less than 1% of amniocentesis procedures. The most serious complication is miscarriage. Other possible, but rare, serious complications include hemorrhage, infection, or injury to the fetus. Minor complications include cramping, vaginal spotting, slight leakage of amniotic fluid, and soreness where the needle was inserted. Early amniocentesis (12-15 weeks gestation) may have a slightly higher risk than standard amniocentesis (after 15 weeks gestation) for pregnancy loss, amniotic fluid leakage, and culture failure.
5. Fewer than 1 in 100 amniocentesis need to be repeated because not enough fluid was obtained the first time. Occasionally, even though fluid is obtained, a diagnosis cannot be made, and the amniocentesis needs to be repeated.
6. The standard testing performed on an amniotic fluid sample is chromosome analysis, which can identify over 99% of chromosomal disorders, and AFP (alpha-fetoprotein) analysis, which can identify over 90% of open neural tube defects. Testing for other conditions will not be performed unless indicated.
7. Normal test results do not guarantee the birth of a normal child. As in any laboratory test, there is a small possibility of error, and maternal cells may contaminate the sample. In addition, 3-5% of all pregnancies have birth defects which cannot be detected by amniotic fluid or by ultrasound examination.

Additional terms of consent/refusal applicable to any screening/testing

1. In the case of twins or other multiple fetuses, the results may pertain to only one of the fetuses.
2. In the case of abnormal diagnostic results, the decision to continue or terminate the pregnancy is entirely mine.
3. The decision to consent to, or to refuse the above procedure is entirely mine.
4. No tests will be performed and reported on my sample other than those authorized by my doctor; and any unused portion of my original sample will be destroyed within 2 months of receipt of the sample by the laboratory.
5. My doctor may release my pregnancy outcome or ultrasound and amniocentesis results to the lab to be used for statistical analysis of laboratory's performance.
6. Laboratories will disclosure the test results ONLY to the doctor named below, or to his/her agent, unless otherwise authorized by patient or required by law.
7. My signature below indicates that I have read, or had read to me, the above information and I understand it. I have had the opportunity to discuss it, including the purposes and possible risks, with my doctor or someone my doctor has designated. I know that I may obtain professional genetic counseling if I wish, before signing this consent. I have all the information I want, and all my questions have been answered.

☐ Yes: I request that Dr. _____ perform amniocentesis or genetic screening/testing marked above. I understand and accept the consequences of this decision.

☐ No: I decline to have amniocentesis, and/or genetic screening/testing offered to me. I understand and accept the consequences of this decision.

Patient's Signature: _____

Witness's Signature: _____

Date: _____/_____/_____

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