

## Laboratory Services

### **AMNIOCENTESIS INFORMED CONSENT AND RELEASE**

#### **TO WHOM IT MAY CONCERN:**

We, the undersigned, have requested of Dr. \_\_\_\_\_ and Ira Salafsky, M.D., that an attempt be made to perform a:

#### ***Chromosome analysis and/or assay for an inborn error of metabolism in our unborn child.***

We understand that the cells required as a basis for such an analysis are obtained in amniotic fluid by a transabdominal amniocentesis procedure, which involves penetrating of the mother's abdominal and uterine walls by hypodermic needle. In addition, alpha-fetoprotein levels in the amniotic fluid will be determined in an attempt to screen for neural tube defects.

The following points have been explained to us and we understand and accept them:

1. The physician may recommend an ultrasonic scan for localization of the placenta and determination of the number of fetuses present.
2. That although transabdominal amniocentesis is a proved technique which has been used extensively, and the hazard to the mother or the fetus is considered to be extremely, small, it cannot be guaranteed that the procedure will not cause damage to the mother or the fetus or initiate premature labor, possibly resulting in spontaneous abortion.
3. That any particular attempt to obtain amniotic fluid by transabdominal amniocentesis may be unsuccessful.
4. That an attempt to obtain a viable tissue culture from the cells of any particular sample of amniotic fluid may be unsuccessful or the chromosome preparations and/or assay may be of poor quality and unusable.
5. That although the likelihood of misinterpretation of the chromosome karyotypes and/or assay in the case is considered to be extremely small, a complete and correct diagnosis of the condition of the fetus based on the karyotypes and/or assay obtained cannot be guaranteed.
6. That a normal chromosome karyotype and a normal alpha-fetoprotein value are not guarantees that the baby will be born without birth defects or mental retardation.

7. I have been advised that Dr. Ira Salafsky will answer any further questions I have concerning these procedures and that I am free to withdraw my consent and to discontinue participation at any time.
8. I understand that the information that is obtained in connection with these procedures will remain confidential and will be disclosed only with my permission or as required by law.

In full recognition of these possible hazards and limitations of the techniques and interpretations involved in the chromosomal analysis and/or assay of our unborn child, we elect to have the analysis attempted and hereby request same.

PATIENT: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_