



Genetic Amniocentesis

1. The purpose of amniocentesis is to detect certain birth defects, including most fetal chromosome disorders. 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 amniocenteses need to be repeated because not enough fluid is obtained the first time. Occasionally, even though fluid is obtained, a diagnosis cannot be made, and the amniocentesis needs to be repeated or further testing might be necessary.

6. The standard testing performed on an amniotic fluid sample is chromosome analysis, which can identify over 99% of chromosomal disorders. Testing for other conditions will not be performed unless indicated in (1) above.

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 testing amniotic fluid or by ultrasound examination.

My signature below indicates that I have read, or had read to me, the above information and I understand it. I have also read or had explained to me the specific disease(s) or condition(s) tested for, and the specific test(s) I am having, including the test descriptions, principles, and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated. I know that genetic counseling is available to me before and after the testing. I have all the information I want and all my questions have been answered. YES: I REQUEST that Dr. Abovyan David perform amniocentesis and/or the genetic screening or testing marked above. I understand and accept the consequences of this decision.

Patient Signature Date Obtained by

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