



STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
 Department of Public Health
 Genetic Disease Screening Program

MR #: _____

Name: _____

**STATEMENT OF INFORMED CONSENT/DECLINE
 TO HAVE AMNIOCENTESIS PERFORMED AT 15
 TO 24 WEEKS OF PREGNANCY**

IMPRINT AREA

1. The purpose of amniocentesis is to detect fetal chromosomal disorders, neural tube defects, and/or other specific disorders of the fetus.
2. Before the amniocentesis is performed I will have an ultrasound examination to help locate the placenta and fetus. Ultrasound may also detect twins, incorrect dating of the pregnancy, and some other conditions.
3. Amniocentesis involves inserting a needle, while watching with ultrasound, through my abdomen into my uterus to sample the fluid that surrounds the fetus. A small amount of fluid (less than one ounce) is taken out and tested. There may be some discomfort when the needle is inserted.
4. Based on currently available information,* minor complications following the procedure may occur, such as vaginal spotting, slight leakage of amniotic fluid, minor cramping, or bruising or soreness where the needle was inserted.
5. Based on currently available information,* there is a minimal increased risk for miscarriage following amniocentesis of about 1 in 900 procedures.
6. Fewer than 1 in 100 amniocenteses must be repeated because a diagnosis could not be made the first time.
7. Amniocentesis can identify more than 99 in 100 cases of chromosomal disorders and, if amniotic fluid alpha fetoprotein analysis is performed, more than 90 in 100 cases of all open neural tube defects. However, a complete and correct diagnosis of the condition of the fetus cannot be guaranteed.
8. Not all birth defects can be detected by amniocentesis or the ultrasound exam.
9. If there are twins or triplets, there may only be results for one of the fetuses.
10. All abnormal findings will be explained to me. The decision to continue or to have the pregnancy terminated is entirely mine.
11. Having an amniocentesis is entirely voluntary. If I do not want this procedure, I will still be eligible for any services supported by State funding.
12. My signature below indicates that:
 I have read, or had read to me, the above information and I understand it. I have had an opportunity to discuss it, including the purpose and possible risks of amniocentesis, with my doctor or the doctor performing the procedure. I have received all of the information that I want. All my questions have been answered.

Yes	I REQUEST that Dr. _____ and/or associates perform amniocentesis. I understand and accept the consequences of this decision. Signed _____ Date _____ Witnessed by _____ Date _____
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No	I DO NOT WANT to have amniocentesis. I understand and accept the consequences of this decision. Signed _____ Date _____ Witnessed by _____ Date _____
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The California Information Practices Act of 1977 (Civil Code 1798 et seq.) requires that the following information be provided. The California State Department of Public Health, Genetic Disease Screening Program, will receive a confidential report of all abnormal tests performed by state-approved Prenatal Diagnosis Centers. This information is collected under the authority of Title 17, California Code of Regulations, Sections 6531 and 6532. This information will be used to ensure that all approved Prenatal Diagnosis Centers meet state standards for services and to improve the detection, prevention, and treatment of birth defects.

If you have any questions, requests, or complaints about the use of your personal health information or desire a copy of the Notice of Information and Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), please contact the Chief of the Genetic Disease Screening Program, 850 Marina Bay Parkway, Richmond, CA 94804, 510-412-1502.

CDPH 4458a English (08-17) Amnio

*ACOG Practice Bulletin, Prenatal Diagnostic Testing for Genetic Disorders, No. 162, May 2016