

EIGHTH AVENUE
OBSTETRICS
@
GYNECOLOGY

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NOTICE AND CONSENT FOR THE FOLLOWING TESTS

The American College of Obstetrics and Gynecology recommends that all pregnant patients be offered the following tests. Please initial and circle accept or decline for each option below:

_____ accept/deline **Obstetrical ultrasound** is a relatively safe method that uses sound waves to obtain pictures to:

- estimate fetal size, maturity and anatomy
- evaluate placental position and location
- discover singleton versus multiple pregnancy(ies)

It is reasonably accurate method for diagnosis (not treatment) that may aid in the management of your pregnancy. Please be advised that like all tests, we cannot guarantee 100% accuracy. It is possible that a defect or problem is falsely reported or not detected at all.

_____ accept/deline **Carrier Screen** (for Hemoglobinopathies, Cystic Fibrosis, Fragile X, and Spinal Muscular Atrophy) is offered to all pregnant women. These diseases are inherited. A positive screen means you are a carrier of a disease, and the father of the baby will need the same screening. If the father is not screened and the mother is a known carrier, the theoretical risk of a child born with cystic fibrosis is 1 in 120. This is a one time test, however, insurance companies may choose not to cover this and fees can be over \$1200.

_____ accept/deline **Non-Invasive Prenatal Testing** is a highly sensitive test done by drawing a mother's blood to test a fetus for Down's Syndrome (trisomy 21), Patau Syndrome (trisomy 13) and Edwards' Syndrome (trisomy 18). It can drawn as early as 10 weeks. It may or may not be covered under insurance and fees can be over \$1000.

_____ accept/deline **Sequential Screen/Nuchal Translucency** is a sensitive test done by performing ultrasound of a fetus as well as drawing a mother's blood to test a fetus for Down's Syndrome (trisomy 21), Patau Syndrome (trisomy 13) and Edwards' Syndrome (trisomy 18) as well as open neural tube defects such as spina bifida.

_____ accept/deline **Blood transfusion** may be necessary during the course of your pregnancy or as a life saving measure. Occasionally, hemorrhage may complicate pregnancy, endangering both mother and fetus. Knowing there is no adequate substitute for blood, transfusion may be necessary to prevent permanent injury or death. Please be advised that risk for HIV transmission is 1/600,000 and hepatitis 1/60/000. When blood transfusion is considered (as a last resort), risk for severe complications without transfusion will be much higher than these risks.

I understand that I may be responsible for payment of any or all of these tests and could owe money to any or all of the following: my insurance company, laboratory companies, and ultrasound companies.

Patient Name

Patient Signature

Witness

Date