NORTH FLORIDA perinatal associates, inc.

☐ Gainesville ☐ Panama City

Consent Form for First Trimester Screening

I have read the patient pamphlet and understand that:

1. The American College of Obstetrics and Gynecology (ACOG) now recognizes first trimester screening (when performed by certified personnel) as a viable choice for fetal genetic risk assessment. (ACOG office of Communications, June 30, 2004)
2. This screen is appropriate for women who will be less than 35 years old at delivery, women who do not have a family history that increases their risk, and women over age 35 who decline invasive prenatal diagnosis but wish to have additional risk assessment upon which to base such a decision. It is standard of care to consider and offer all women who are 35 years or older an amniocentesis or chorion villus sampling. Genetic counseling is recommended for all women age 35+ to review these options in detail.
3. This screen gives my obstetrician and me information regarding the health and genetic risk of my baby.
4. This screen is designed to identify babies who may have an increased risk of having a chromosome abnormality such as Down syndrome (Trisomy 21) or Trisomy 13 or 18.
5. If my screening test shows an increased risk, it does not mean a problem has been diagnosed, only that my pregnancy should be further evaluated.
6. If my screening test shows a result in the "normal range" it does not guarantee that my baby is normal. Other problems including chromosome abnormalities may be present or develop in your baby.
7. My healthcare provider(s) may release my ultrasound, chorion villus sampling, amniocentesis, and pregnancy outcome results to the laboratory for quality control purposes.
8. I understand there are benefits and limitations of this test, including the possibility of false positive and false negative results.
9. All my questions have been satisfactorily answered.
10. My visit to North Florida Perinatal Associates today was to specifically undergo first trimester screening. Any other pregnancy related concerns have to be addressed with my obstetrician, or during a separate consultation with either a perinatologist or genetic counselor on an as-needed basis as determined by my obstetrician.
11. I understand that my insurance company may not cover this service, and agree to provide payment on the day of the procedure.
12. I consent to having an ultrasound and my blood drawn in order to pursue first trimester screening.

Patient Name (Print): _____

Patient Signature: _____ Date: ___/___/___

Witness Signature: _____ Date: ___/___/___