INFORMED CONSENT AND RELEASE FOR DIAGNOSTIC AMNIOCENTESIS

I, ____, herby request and authorize **Dr.** _____________________________________ and associates to perform sonography (ultrasound) and a diagnostic amniocentesis (withdrawal of amniotic fluid through needle passed into the uterus through the abdominal wall), and to biochemical status (relating to ________________________________) of the unborn baby (fetus). It has been explained to me and I understand that:

1. These procedures involve a small risk to both mother and fetus, and I realize that miscarriage is a possible complication.
2. More than one amniocentesis may be necessary to obtain the required fluid.
3. There is the possibility that the cell cultures, the chromosome analysis and/or the biochemical analyses may not be successful.
4. It is possible that the results of the chromosomes and/or biochemical analyses may not accurately reflect the status of the fetus.
5. If I am pregnant with more than one fetus, the results might pertain only to one fetus.
6. The finding of normal chromosome constitution or normal biochemical status does not eliminate the possibility that the child may have birth defects and/or mental retardation.

This amniocentesis is being performed for the following reasons:
____
____
Signed:___________________________ Witness: __________________________
Date: ___/___/_____

I consent to the use of any remaining cells and fluid for additional studies relating to this pregnancy or for the purpose of research in prenatal diagnosis.
Signed: ___________________________ Witness: __________________________
Date: ___/___/____

I do not wish to have amniocentesis for prenatal diagnosis in this pregnancy.
Signed: _______________________________ Witness: ______________________
Date: ____/____/_______