TLV MEDICAL

טופס הסכמה
לדיקור שק השפיר לצורך איבחון גנטי

CONSENT FORM FOR AMNIOCENTESIS FOR GENETIC DIAGNOSIS

Amniocentesis is performed to diagnose genetic disorders, diseases or birth defects that can be diagnosed prenatally within existing limitations. The examination is generally performed in Week 16-22.5 of pregnancy.

The examination is performed by inserting a needle through the abdominal wall into the uterus, under ultrasound guidance, and collecting approximately 30-40cc of amniotic fluid. Occasionally, more than one puncture may be required to obtain a sufficient amount of amniotic fluid for the test. In a multifetal pregnancy, a separate puncture is needed for every sac.

The examination is highly reliable with regards to chromosomal defects that were tested but an examination that is interpreted as normal does not completely rule out the existence of defects or genetic diseases that were not tested for or that cannot be tested in amniotic fluid.

The examination is performed without anesthesia.

A comprehensive report of genetic diseases in the family and on tests performed for the couple to detect genetic disorders and on the scans performed to detect genetic disorders during the current pregnancy is critically important.

I hereby declare and confirm that I have been given an explanation of the alternative modes of treatment that are possible in the circumstances of the case, as well as of the side effects, prospects and complications that these treatments involve, including information on maternal blood test to detect chromosomal defects.

I request and consent to perform the amniocentesis to examine the chromosomes of the fetus that I am carrying in my uterus and any other genetic test of the amniotic fluid that my doctor deems necessary, based on medical information, to diagnose genetic disorders, diseases or birth defects that can be diagnosed prenatally within existing limitations.

I have been given an explanation of the possibility that the puncture might fail, or that the cell culture obtained will not grow, or that the results might not be conclusive and that the examination might need to be repeated.

I declare and confirm that I was given an explanation that following the examination, I might experience sensitivity or pressure in the lower abdomen and possible mild pain at the injection site, mild vaginal bleeding and mild leak of amniotic fluid. In addition, I was given an explanation that normal results of the examination do not guarantee that the baby will be free of physical, mental or intellectual defects, including genetic defects or diseases that were not tested for or that could not be tested through the amniocentesis.

I was also given an explanation about the possible complications including miscarriage in 0.5% of cases, rare occasions of physical injury to the fetus and development of infection that might require a hysterectomy, and on extremely rare occasions, might result in death.

Another puncture performed in proximity to the first puncture increases the risk of the aforementioned complications.

I hereby give my consent to perform the examination, and if in light of the examination results, the pregnancy will be terminated, I also grant my consent to the autopsy of the aborted fetus.

Patients signature: _____ חתימת המטופלת:

רחוב הברזל 15 תל-אביב, טל: 077-9807500 פקס: 077-9807534

Before the puncture, I was given an explanation of the other available tests that can be performed on culture of amniotic fluid cells for a fee (more information can be provided to interested parties).

***Amniotic fluid cells are stored for only 3 weeks. Beyond this time, the procedure for storing and growing the cells involves a fee.**

Woman's Name: _____ _____ _____ _____
(שם האישה) Last Name / שם משפחה First Name / שם פרטי Father's Name / שם האב ID No. / ת.ז.

I hereby declare and confirm that I have been given a detailed oral explanation by Dr./genetic counsellor (מרופא/יועץ גנטי):

_____ _____
Last Name / שם משפחה First Name / שם פרטי

about the amniocentesis to detect any deficiencies in the fetus due to (בשל): _____
(Henceforth: "The primary examination").

_____ _____ _____
Date / תאריך Time / שעה Woman's Signature / חתימת האישה

_____ _____
Name of Guardian (Relationship)/ שם האפוטרופוס (קרבה) Guardian's Signature (for incompetent, minor or mentally ill patients)/ חתימת האפוטרופוס (במקרה של פסול דין, קטין או חולה נפש)

I hereby confirm that I have given the patient (לאישה) / the patient's guardian (לאפוטרופוס של האישה)* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

אני מאשר/ת כי הסברתי בעל פה לאישה / לאפוטרופוס של האישה* את כל האמור לעיל בפירוט הדרוש וכי הוא/היא חתם/ה על הסכמה בפני לאחר מענה על שאלות שנשאלו ושוכנעתי כי הבין/ה את הסברי במלואם.

_____ _____ _____
Name of Physician / שם הרופא/ה Signature / חתימה License No. / מספר רישיון

* Cross out irrelevant option / מחק/י את המיותר