MATERNAL-FETAL MEDICINE
Community Health Network

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Amniocentesis for Paternity Testing Consent

I understand that I am electing to undergoing amniocentesis for prenatal paternity testing. The testing is for the determination of paternity of only. I will not receive any other information from this testing.

I, _____ am requesting that

_____M.D. make an attempt to perform genetic amniocentesis for analysis of fetal cells that are obtained from the amniotic fluid surrounding the unborn baby by a procedure called transabdominal genetic amniocentesis. This procedure involves the penetration of my abdominal wall and the wall of my womb (uterus) by a needle. A syringe is then used to aspirate approximately one ounce (30 ml) of amniotic fluid.

Advantages:

1. Transabdominal genetic amniocentesis is a proven technique which is widely used.
2. Ultrasound guidance will be used to decrease the probability of damage to my unborn baby, the placenta (afterbirth), or the uterus.
3. In most cases paternity may by accurately determined or excluded. I will receive the results of the paternity testing directly from the laboratory chosen to perform the testing.

Risks:

1. There is a possibility (usually reported at 1 in 200 attempts) that the procedure may cause damage to myself or my unborn baby. This can include bleeding, infections, premature labor, leaking of amniotic fluid, miscarriage or amniotic embolism.
2. Any attempt to obtain amniotic fluid by genetic amniocentesis may be unsuccessful.
3. Any attempt to obtain a viable tissue culture from the cells of any sample of amniotic fluid may be unsuccessful. Tissue culture may fail for many technical reasons unrelated to the amniocentesis or the quality of the amniotic fluid obtained.
4. Preparations of the sample may be of poor quality and unsuitable for accurate diagnosis.
5. The likelihood of misinterpretation of paternity is less than 1%.

I therefore permit the doctor and such other persons as are needed to assist him/her to perform this procedure.

_____ _____ _____ _____
Patient's Signature Date Time am/pm

_____ _____ _____ _____
Witness Date Time am/pm

The patient is unable to consent because: _____

I therefore consent for the patient: _____ _____
Signature Relationship to Patient