מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:
שם משפחה: שם פרטי:
שם האב: תאריך לידה:
כתובת:
טלפון: **מדבקת פרטי מטופל**

טופס הסכמה: דיקור שק השפיר לצורך אבחון גנטי

CONSENT FORM: AMNIOCENTESIS

Amniocentesis is carried out for diagnosis of genetic disturbances, diseases or congenital abnormalities that can be diagnosed prenatally under existing limitations. The examination is usually done in the 16th-20th week of pregnancy.
The examination is performed by inserting a needle through the abdominal wall into the uterus under ultrasound guiding, and aspiration of 30-40 ml of amniotic fluid. Sometimes there is need for more than one puncture in order to produce sufficient amniotic fluid for the examination. In a multiple pregnancy there is a need for a separate puncture for each sac. The test is of high reliability for the chromosomal abnormalities being examined, but a test interpreted as normal does not entirely rule out the presence of abnormalities or hereditary diseases that are not examined or cannot be examined in amniotic fluid.
The operation is carried out without anesthesia.

It is of major importance to report fully on genetic diseases in the family and on examinations performed for the detection of genetic disturbances.

Name of Woman: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from the physician/genetic consultant*:

_____ _____
Last Name First Name
regarding amniocentesis in order to reveal abnormalities in the fetus because of _____
_____(henceforth: "the examination").

I hereby request and consent to perform amniocentesis for the examination of chromosomes of the fetus in my uterus and also any other genetic examination of amniotic fluid that my physicians find necessary on the basis of medical information, in order to diagnose genetic disturbances, diseases or congenital abnormalities as far as possible for prenatal diagnosis under existing limitations.
It has been explained to me that there is the possibility that the amniocentesis may not succeed, or that culture of the cells obtained may not grow, or that the results will not be unequivocal and that it will be necessary to repeat the examination.
I hereby declare and confirm that it has been explained to me that after the examination has been performed a feeling of sensitivity or pressure in the lower abdomen is to be expected and possibly mild pain at the site of the puncture, slight vaginal bleeding and slight leakage of amniotic fluid. It has also been explained to me that normal results of the examination do not ensure that the newborn infant will be free of physical, mental or psychological defects including hereditary diseases or defects that were not or could not be examined by examination of amniotic fluid.
The possible complications have also been explained to me including abortion (miscarriage) in 0.5% of the cases; in rare cases physical damage to the fetus and also development of infection that is liable to necessitate hysterectomy and in very rare cases may cause death.
An additional puncture performed near the previous one increases the risk of complications described above.
I hereby give my consent to perform the examination. If in the light of the results of the examination the pregnancy is terminated, I agree to a pathological examination of the aborted fetus.

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

I know and agree that the examination and all other procedures will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

Date	Time	Patient's Signature

I hereby confirm that I provided the woman with a detailed verbal explanation of all the abovementioned, as required, and that she signed the consent form in my presence after I was convinced that she fully understood my explanations.

Name of Physician	Physician's Signature	License No.

* Cross out what is irrelevant.