AMNIOCENTESIS
PROCEDURE EDUCATION LITERATURE AND CONSENT FORM

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. “An educated patient is the best patient.”*

Amniocentesis is a procedure in which a long thin needle attached to a syringe is inserted through the abdomen and into the uterus to withdraw amniotic fluid.

The risks of the procedure include, but are not exclusive to, bleeding, infection, fetal or placental injury, and a risk of miscarriage of approximately 1:250. It is also understood that normal results on any single test are not a guarantee of a normal baby.

I was informed of the risks involved if amniocentesis is not performed and of possible alternative methods of diagnosis and treatment including their risks.

**Consent for Treatment**

I understand that during the course of the procedure unforeseen conditions might arise or be revealed that could require an extension of the procedure or performance of other operations, procedures or treatments. I therefore authorize and request the below-named individual or their designees to perform such operations, procedures or treatments that are or might become necessary in the exercise of their professional judgment.

I acknowledge that __________________ has explained the proposed operation to me and has answered any questions that I have to my satisfaction.

I hereby consent to the above procedure. In addition, I accept all of the risks inherent to that operation and request that it be performed.

_________________________________________  ________________  ________________  ____________
Patient Signature  Patient Name (Printed)  Patient ID  Date

_________________________________________  ____________________________  ____________
Physician Signature  Physician Name (Printed)  Date

_________________________________________  ____________________________  ____________
Witness  Witness Name (Printed)  Date

*The information contained in this Medical Informed Consent Form (“Consent Form”) is intended to solely inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional.*

*Please call your doctor if you have any questions.*

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