Maryanne McDonnell, M.D.
Martin J. Hancock, M.D.
Katerina M. Michaels-Bogdan, M.D.
Danielle M. Grieco, M.D.
Sarah E. Graceffa, M.D.

OBGYN Group of Eastern Connecticut

Katherine Riddle, M.D.
Pamela Frappier, PA-C
Alexis K. Warren, CNM
Josie Dumond, APRN
Richard Wintermute, M.D.

# PRENATAL TESTING CONSENT FORM

Below is a list of screening tests available to you. These tests are not always accurate. **False positives, as well as false negatives might occur. Normal tests do not guarantee your baby will be perfectly healthy**. If any of the tests come back abnormal, additional testing may be recommended.

## Carrier Screening: Cystic Fibrosis (CF), Spinal Muscular Atrophy (SMA), Fragile X

**Blood test** in our office – can be **drawn anytime and does not need to be repeated with your next pregnancy**. It checks to see if you are a carrier of the most common gene mutations causing cystic fibrosis, a very serious lung disease with an average life expectancy of 40 years. The carrier rate is as high as 1/24 in some high risk populations. SMA is a serious muscular disease that often severely shortens life expectancy and has a carrier rate as high as 1/47 in some high risk populations. Fragile X is a gene mutation associated with mental retardation.

| Accept: | Decline: |
|---|---|

## Cell Free DNA

**Blood test** in our office– **drawn at the 12 week visit (or anytime after 12 weeks of pregnancy), screens for trisomy 13, 18, and 21. This test is also able to identify the fetal sex. This does not screen for open neural tube defects.**

| Accept: | Decline: |
|---|---|

## AFP Only

**Blood test** in our office – **drawn at the 16 week visit, screens for open neural tube defects only. This does not screen for trisomy.**

| Accept: | Decline: |
|---|---|

## Nuchal Translucency Ultrasound

**Ultrasound** at Maternal Fetal Medicine office – **performed between 11-13 weeks**, **screens for chromosomal abnormalities and major congenital heart problems.** Occasionally other rare genetic disorders are detected.

| Accept: | Decline: |
|---|---|

## Level II Ultrasound

**Ultrasound** at Maternal Fetal Medicine office – **performed at 18+ weeks, replaces the standard anatomy scan done in the office for women with an increased risk of fetal abnormalities or medical conditions requiring a high-risk consultation.**

| Accept: | Decline: |
|---|---|

## Invasive Fetal Testing

**Collection of fetal cells** at Maternal Fetal Medicine office – this testing includes both **chorionic villi sampling and amniocentesis**. It is the only fetal testing that can be used to **officially diagnose** (instead of screen for). Both tests involve inserting a needle into the uterus and collecting fetal cells from the placenta or amniotic fluid which are used for genetic diagnosis.

| Accept: | Decline: |
|---|---|

**My provider has discussed all testing options available with me, reviewed benefits and risks, and answered all of my questions to my satisfaction. I understand that certain prenatal genetic testing may not be covered by my insurance. If I elect to have any of the genetic testing done during my pregnancy, whether on me, or the father of my baby, and it is not covered by my insurance, I understand and agree that I am responsible and will pay in full for all laboratory costs of such testing.**

**Patient signature: _____**

**Today's date: _____**