



WOMEN'S MEDICAL GROUP  
OBSTETRICS – GYNECOLOGY – INFERTILITY

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### AFP Consent

1. I have read the information about the California Expanded AFP screening Program which is contained in the booklet given to me by my physician.
2. I have been informed that:
  - a. The purposed of the California Expanded AFP Screening Program is to detect most fetuses with open neural tube defects, abdominal wall defects, Down syndrome, and trisomy 18. However, not all such defects can be detected by the Program.
  - b. There are other birth defects that cannot be detected by this Program
  - c. If the result is “screen positive,” I will need to make a decision regarding follow-up testing. Authorized follow-up tests are covered by the Program and will be discussed with me in more detail.
  - d. If the result is “screen negative,” the Program will not pay for any follow-up testing.
  - e. If the fetus is found to have a birth defect, the decision to continue or terminate the pregnancy will be entirely mine.
  - f. Participation in the California Expanded AFP Screening Program is voluntary. I can refuse any tests at any time.
3. I have read the detection rates for certain birth defects as they are described in this booklet.
4. I have been informed that a blood specimen for the California #Expanded AFP Screening Program is only reliable between 15 and 20 weeks of pregnancy.
5. I have had my questions answered to my satisfaction.

<p>Yes, I request that blood be drawn for the Expanded AFP Screening Program.</p> <p>Signed _____ Date _____</p> <p>I should have my blood drawn between: _____ and _____</p>
<p>No, I request that blood <b>not</b> be drawn for the Expanded AFP Screening Program.</p> <p>Signed _____ Date _____</p>

*I understand that the blood specimen and information obtained during the testing process become the property of the California Department of Health Services. They may be used for program evaluation or research by the Department or Department-approved scientific researchers without identifying the person or persons from whom these results were obtained, unless I specifically prohibit such use in writing. All information procured by the Department of Health Services, or by any other person, agency or organization acting jointly with the Department in connection with such special studies, shall be confidential. I may obtain additional information about the study or prohibit the use of my specimen by writing George Cunningham, MD, MPH, Genetic Disease Branch, 2151 Berkeley Way, Annex 4, Berkeley, CA 94704.*

*If new information becomes available about a birth defect detected during this pregnancy, the information may be sent to me unless I specifically prohibit it by writing to George Cunningham, MD, MPH at the above address.*