Consent or Decline

CLINICIAN COPY

MUST BE FILED IN PATIENT CHART

California Prenatal Screening Program

1. I have read the information in this booklet (or have had it read to me).
2. I understand that:
	1. The Prenatal Screening Program offers prenatal tests for the detection of birth defects such as Down syndrome, Trisomy 18, Trisomy 13, Smith-Lemli-Opitz syndrome (SLOS), Neural Tube Defects, and Abdominal Wall Defects. These birth def4ects cannot be detected 100% of the time.
	2. There is a Program fee charged to the patient. This fee may be covered by health insurance. I agree to pay any part of this fee not covered by insurance.
	3. If the blood test result is Screen negative, the Program will not pay for any follow-up testing.
	4. If the blood test result is Screen Positive, I will need to make a decision regarding follow-up diagnostic testing.
	5. If the fetus is found to have a birth defect, the decision to continue or terminate the pregnancy is entirely mine.
	6. There are birth defects that cannot be detected with screening tests.
3. I also understand that:
	1. Participation in the Prenatal Screening Program is voluntary. I can decline any test at any time.
	2. Consent to participate in the Program may include Quad, Serum or Full Integrated Screening.

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| --- | --- | --- |
|   |   |   |
|   |   | I consent to participate in the California Prenatal Screening |
|   |   | Program. I request that blood be drawn for Prenatal Screening. |
|   |   |   |
|   |   | I agree that my specimen may be used for research by the  |
|   |   | Department of Public Health, or Department approved |
| **YES** |  | researchers, unless I mark the box below. |
|   |   |   |
| I Consent  |   |  □ I decline the use of my specimen for research |
| to Screening |   |   |
|   |   | The Department will maintain confidentiality according  |
|   |   | to applicable laws and regulations. |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   | Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
|   |   |   |
|   |   | I decline to participate in the California Prenatal Screening  |
|  |   | Program. I request that blood not be drawn for Prenatal |
| **NO** |   | Screening.  |
|   |   |   |
| I Decline |   |   |
| Screening |   |   |
|   |   | Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ |