

Disclosure and Consent Regarding Diagnostic Procedures

To the Patient: You have the right as a patient, to be informed about your condition and the recommended diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and limitations involved. The purpose of this disclosure is not to scare or alarm you but rather to make you better informed so you may give or withhold your consent to the procedure.

General Limitations Concerning Obstetrical Scanning:

- ◆ The accuracy of the ultrasound for dating a pregnancy depends on what point the ultrasound is taken. The accuracy declines as the pregnancy progresses.
- ◆ The ability to detect fetal abnormalities in an ultrasound exam depends on the size and the position of the fetus, the amount of amniotic fluid, the mother's body type and difficulty in obtaining views. Although a normal ultrasound is reassuring, there is a 2% chance of having a baby with an abnormality not seen on today's ultrasound.
- ◆ Not every problem that may be detected will be diagnosed (For example, normally the baby's fingers and toes are not counted, although it may be possible to do so).
- ◆ There are possible negative psychological effects to early and false positive diagnosis of fetal abnormalities.

General Limitations Concerning All Ultrasound Studies:

- ◆ There is only an estimate of ultrasound accuracy in detecting abnormalities
- ◆ There are both false negative and false positive results.
- ◆ The ability to detect abnormalities in an ultrasound exam varies depending on the patient's body type.

I, _____ (print name), voluntarily request _____ as my midwife/nurse practitioner, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition.

I understand that the following diagnostic procedure is planned for me and I voluntarily consent to and authorize the following procedure: (*circle one*)

Obstetrical U/S or Gynecological U/S

I understand that no warranty or guarantee has been made to me as to result or finding. In the event that a physician consult is indicated, a subsequent office visit will be scheduled at an additional cost of \$65.00.

I certify that I have read this form and understand its contents. I also certify that I recognize the limitations of this ultrasound examination and do not hold the professionals performing this test responsible for the problems that may not be detected.

Patient/or Other Legally Responsible Person Signature

Date

Witness