

Statement of Informed Consent for Maternal Serum Screening (AFP)
Cascade Family Medicine

I understand that maternal serum screening may detect neural tube defects such as spina bifida and anecephaly, abdominal wall defects and Down's Syndrome. However, I realize that the test will detect only 85% of Down's Syndrome. I understand that a normal test does not guarantee my baby is normal.

I understand that if my test returns abnormal, an ultrasound and amniocentesis may be offered to determine the cause of the abnormal test. These tests will be discussed in more detail if needed. I understand that most abnormal tests will occur with normal babies.

I understand that some infants may be born with serious birth defects. The purpose of the MSAFP/hCG test is to help identify some of the effected fetuses.

I understand that I may refuse this test without any consequence to me.

I have had an opportunity to discuss MSAFP/hCG screening with my health provider.

YES: I request that blood be drawn for the MSAFP/hCG screening test. I Understand the reasons for this test.

Signed: _____ Date: _____

NO: I do not want the MSAFP/hCG test. I understand and accept the Consequences of this decision.

Signed: _____ Date: _____

Witness: _____ Date: _____