

Name: _____ D.O.B. ____/____/____

CONSENT TO PRENATAL CARE AND DELIVERY

1. I hereby authorize Dr. Teresa Hoffman, MD & Associates and/or such assistants as may be selected and supervised by her to treat the following condition(s): **Pregnancy and Delivery (including vaginal or Cesarean section, if necessary)** by performing the following diagnostic, therapeutic, or surgical procedures: **Prenatal care, blood work, urine testing, ultrasound, fetal monitoring, delivery of infant by vaginal or abdominal route as indicated, and circumcision of male infant (if I so request).**
2. I have been advised of the nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, the possible consequences, the possibility of complications and the prognosis if no treatment is rendered. Additionally, I have been advised that if I desire a further and more detailed explanation of any of the foregoing or further information about the possible risks or complications of the above-listed procedures, it will be given to me upon my request.
3. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment.
4. I have had sufficient opportunity to discuss my condition and treatment with the doctor and her associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed treatment.
5. I understand that during the course of the procedure described above, unexpected circumstances may develop or my physician may discover an unforeseen condition. I therefore authorize and request that my physician and her designated assistant(s) perform such procedures that they determine to be medically necessary due to such unforeseen circumstances or conditions.
6. During my stay at the hospital, I authorize the administration of blood or blood products when and where necessary (as a life-saving measure) should they occur.
7. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ, UNDERSTAND, AND AGREE WITH IT.

Signature of Patient

Signature of Witness

AFFIRMATION OF INFORMED CONSENT BY PHYSICIAN

I have explained to the patient, or to the person legally authorized to act on behalf of the patient, the treatments and procedures described in this permit, and I have explained to the consenting party the nature, methods, risks, alternatives, and possible complications of these treatments and procedures.

Date

Signature of Health Care Provider

CONSENT FOR QUAD SCREENING

As part of my prenatal care, the Healthcare providers at Teresa Hoffman, MD & Associates, LLC have offered a prenatal test, the Quad Screen, to me. I will only be offered the MSAFP test if I under first trimester serum screening through the Center for Advanced Fetal Care. I have been advised that it is a blood test that is used to help detect neural tube defects (abnormal development of a baby's brain and spine) and chromosomal abnormalities (such as Down's Syndrome and Trisomy 13/18). Neural tube defects can result in a baby that is paralyzed or mentally retarded. Chromosomal abnormalities such as those mentioned also result in mental retardation and severe developmental abnormalities.

I have been advised that this is only a blood test and as such, carries no risk to the pregnancy. I have also been advised that it is not 100% accurate. It may sometimes indicate that my baby is at increased risk for these problems when my baby is normal. It may also indicate that my blood test is normal when my baby has one of these conditions.

I have decided that:

I want to have this blood test done.

I do not want to have this blood test done.

I acknowledge that it has been fully explained to me that by failing to consent to this test, I am preventing the possible detection of these abnormalities at a point in the pregnancy when alternatives to birth are still available. I acknowledge that in choosing to have this blood test done, false positive and false negative results do occur and that I will not hold my healthcare providers responsible for such results.

Signature of Patient

Date

Signature of Health Care Provider