טופס הסכמה: בדיקת סיסי שליה/ביופסיה משליה

CONSENT FORM: CHORIONIC VILLUS BIOPSY (CVS)/ PLACENTAL BIOPSY

Chorionic villus biopsy or placental biopsy is performed out for the purpose of diagnosis of genetic disturbances, diseases or congenital abnormalities that can be diagnosed under the existing limitations.
The examination is usually performed during the 10^{th}-12^{th} week of pregnancy.
The advantage of the examination is the ability to locate chromosomal abnormalities or diseases at an early stage of pregnancy and when necessary, to terminate the pregnancy by means of curettage.
The examination may be carried out in two ways:

a. Introduction of a thin tube through the vagina up to the placenta under ultrasound guidance.
b. Puncture of the placenta through the wall of the abdomen and the uterus.

The position of the placenta determines the way in which the procedure is done. In a multiple pregnancy a separate puncture is needed for each placenta.
The examination has high reliability for chromosomal abnormalities that are examined, but an examination that is reported as normal does not entirely exclude the existence of hereditary abnormalities or diseases that were not tested for or cannot be tested by examination of the placenta.
The operation is carried out without anesthesia or with local anesthesia.
It is of major importance to report fully on genetic diseases in the family and examinations performed for the detection of genetic disturbances.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the need for an **chorionic villus/placental* biopsy** in order to detect fetal abnormalities because _____(hereafter: the examination).
The diagnostic alternatives, their advantages, disadvantages and side effects have been explained to me.
I hereby request and consent to perform the biopsy for examination of chromosomes of the fetus in my uterus and also any other genetic examination of the placenta that my physicians find necessary, on the basis of medical information, in order to diagnose genetic disturbances, diseases or congenital abnormalities feasible for prenatal diagnosis under the existing limitations
It has been explained to me that there is a possibility that the puncture or introduction of the tube may not succeed, or that the culture of the cells obtained will not grow, or that the results will not be unequivocal and it will be necessary to repeat the puncture or introduction of the tube, or perform amniocentesis.
It has also been explained to me that normal results of the examination do not ensure that the newborn infant will be free of physical, mental or psychological defects including hereditary diseases or defects that were not or could not be examined by chorionic villus or placental biopsy.
I hereby declare and confirm that it has been explained to me that after the examination a feeling of sensitiveness or pressure in the lower abdomen is expected and possibly mild pain at the site of the puncture and slight vaginal bleeding.

The possible complications have also been explained to me, including abortion (miscarriage) in 1% of the cases, in rare cases physical damage to the fetus and also development of infection that is liable to necessitate hysterectomy and in very rare cases may cause death.
An additional puncture that is performed near the previous one increases the risk of complications detailed above.
I hereby give my consent to perform the examination. If in the light of the results of the examination the pregnancy is terminated, I agree to a pathological examination of the aborted fetus.
I hereby consent also to the performance of local anesthesia after I have received an explanation regarding the possible complications of local anesthesia including an allergic reaction of varying degree to the anesthetic substances.
I know, confirm and agree that the primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

_____	_____	_____
Date	Time	Patient's Signature

I hereby confirm that I provided the woman with a detailed verbal explanation of all the abovementioned, as required, and that she signed the consent form in my presence after I was convinced that she fully understood my explanations.

_____	_____	_____
Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.