

## Obstetrical Counseling/Consent

PLEASE PRINT, SIGN AND BRING THIS PAGE TO YOUR PRENATAL VISIT

Insurance coverage for these tests/services vary. If you need clarification on what your insurance may or may not pay for these services, please contact them directly.

I have read and understand the information regarding the following testing:

1. I agree to the standard of care for prenatal lab work which includes HIV testing. Other tests may be indicated depending upon your particular case.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. **Cystic Fibrosis Screening**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

3. **Spinal Muscular Atrophy (SMA)**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

4. **Fragile X Syndrome**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

5. **Sequential Screen/Nuchal Translucency**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

6. **Quad Screen**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

7. **Third Trimester HIV Testing**

Yes, I desire testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

No, I decline testing. Signature: \_\_\_\_\_ Date: \_\_\_\_\_