

Signature Page for Prenatal Tests

The following tests are standard during pregnancy, but families receiving care at Mother's Own Birth and Women's Center may decide whether they wish to be tested. Please read the information sheet for each of these tests before consenting or declining any of these tests. Please initial and date the appropriate section for each test.

HIV Testing

_____ **Yes**, I want to be tested for the HIV antibody.
_____ **No**, I do not want to be tested for the HIV antibody.

Prenatal Screen

I have read and understand the information provided about prenatal fetal screening test. I understand that for the test to be accurate an accurate gestational age must first be established.

_____ **Yes**, I would like to have the following tests performed and understand that some of these tests may only be performed by an obstetrician or perinatologist.

- _____ Chorionic Villi Sampling (CVS) at 11-12 weeks
- _____ First Trimester Chromosome and Anomaly Screening at 11-14 weeks (free Beta/PAPP-A / Nuchal Translucency)
- _____ Triple/Quad Screen at 15-19 weeks
- _____ AFP only screen at 15-19 weeks (follows the First Trimester Chromosome and Anomaly Screen)
- _____ Normal anatomy ultrasound at 20-22 weeks

_____ **No**, I do not wish to have any of the prenatal fetal screening tests performed.

Glucose Tolerance Test

I have read and understand the information about gestational diabetes and the one hour glucose tolerance test (GTT) as outlined in the information packet. The midwives have provided me with information regarding reasons for testing as well as risks, benefits, advantages, disadvantages and side effects of various therapies used to treat gestational diabetes. I have had all my questions answered to my satisfaction.

_____ **Yes**, I am interested in being tested for gestational diabetes at 26-28 weeks in my pregnancy. I understand that should the 1 hour GTT screening test is positive, a 3 hour GTT and consultation with a physician will be recommended

_____ **No**, I am not interested in being tested for gestational diabetes at 26-28 weeks in my pregnancy. I may choose to reevaluate my position on this matter should signs of diabetes develop.

Group B Strep

I have read and understood the information about GBS as outlined in the information packet. The midwives have provided me with information regarding reasons for testing as well as risks, benefits, advantages, disadvantages and side effects of various therapies used to treat GBS. I have had all my questions answered to my satisfaction.

_____ **Yes**, I wish to be tested for GBS at the appropriate time in my pregnancy. I understand that Mother's Own Birth and Women's Center, LLC is not able to administer IV antibiotics to me (as per 2003 CDC guidelines). If I do wish to receive IV antibiotics during labor, I understand that I will need to transfer to a facility that offers this therapy. I agree to using appropriate alternative GBS prophylaxis therapies, such as Hibiclens periwashes.

_____ **No**, I am not interested in being tested for GBS at the appropriate time in my pregnancy. Nor, am I interested in receiving IV antibiotics or in being treated for potential GBS infection during labor with IV antibiotics based on the risk factors outlined. I may choose to reevaluate my position on this matter should risk factors develop.

Signature of mother: _____ Date: _____

Signature of CNM: _____ Date: _____