ORIGINAL COPY TO BE RETAINED BY THE CLINICIAN

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Information and consent form for pregnant women

for the collection of a sample and the performance of one or more tests for the purposes of prenatal diagnostics in utero (as per Article R. 2131-1 of the French Public Health Code)

I, the undersigned, ...

confirm that the doctor *(Surname, First Name)* : .....

as part of a medical consultation on *(date):* |_|_| |_|_| |_|_|_|_|

1. Has given me information about:

- the risk of the unborn child being born with a particularly serious condition;
- the characteristics of this condition;
- the means of diagnosing it;
- the possible opportunities offered by foetal medicine for the treatment or care of the child after birth;

2. Has given me information on the laboratory tests that could establish a prenatal diagnosis in utero; these tests have been offered to me and I wish to receive them:

- this (these) test(s) require(s) a sample of amniotic fluid, chorionic villi (placenta), foetal blood, or other foetal sample;
- the methods, risks, constraints and possible consequences of each sampling technique needed to perform this (these) test(s) have been explained to me;
- I have been informed that a second sample may be needed in the event of technical failure; in this event, I will need to sign a new written consent form;
- I have been informed about possible conditions other than those initially investigated that could be revealed by the examination;
- I have been informed that the result of the test will be given to me and explained by the doctor who prescribed it to me.

I give my consent for the sampling of (required for the conduct of the test(s)) (*):

- amniotic fluid
- chorionic villi
- foetal blood
- other foetal sample (please specify)

I also give my consent for the test or tests (*) for which the sample is being collected:

- cytogenetic tests, including molecular tests applicable for cytogenetics
- molecular genetics tests
- foetal biochemistry tests for diagnostic purposes
- laboratory tests for the diagnosis of infectious diseases

This (or these) test(s) will be carried out in a medical laboratory that is duly authorized by the regional health agency to conduct them.

The original copy of this document will be stored in my medical records.

A copy of this document will be given to me and to the person responsible for conducting the tests.

The medical laboratory in which the person responsible for conducting the tests is employed shall keep this document under the same conditions as the report of the examination.

(*) Delete as applicable

Date : |_|_| |_|_| |_|_|

Signature of the clinician	Signature of the interested party

COPY TO BE SENT TO THE LABORATORY

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Signature of the clinician	Signature of the interested party

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COPY TO BE RETAINED BY THE PATIENT

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