Informed Consent for Chromosome Analysis and/or Fluorescence In Situ Hybridization (FISH) on Abortus Tissue

Studies on tissue from first trimester miscarriages indicate that 50% of these early losses result from chromosome abnormalities and in second trimester losses 20% result from chromosome abnormalities. Most of these are sporadic in nature, and therefore, do not incur an increased risk for chromosomal abnormalities in future conceptions. In a small percentage of couples (less than 5%), one of the parents carries a rearrangement of his/her chromosomes which predisposes future pregnancies to a higher risk for chromosomal abnormalities.

Chromosome studies on this miscarriage have been recommended by your doctor as part of his/her evaluation for the cause of your miscarriage. You should be aware that the tissue may not grow in the laboratory. In this event, we will perform fluorescence in situ hybridization (FISH) with a panel of probes that detects approximately 80% of the abnormalities present in abortuses. This testing takes approximately two weeks. In a small number of cases, we will not be able to perform chromosome analysis or FISH on the specimen and will be unable to provide an analysis.

The nature of cytogenetic testing has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that while results obtained from this testing are usually highly accurate, infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

I understand that this testing may yield results that are of unknown clinical significance and that parental or other relatives blood samples may be also be tested to determine whether a specific finding was inherited.

No test will be performed and reported on my sample other than the one(s) authorized by my doctor.

I give consent to have my specimen be used anonymously by the laboratory for the purposes of quality control or for research related to genetic disease. Please check the box below to consent. If you do not consent your sample will be discarded within 2 months of completion of the testing.

☐ I agree to have my sample used anonymously for research by the laboratory.  

Initial  

The results of my test will be explained to me by my physician or by a genetic counselor, who will have the opportunity to discuss my results with a clinical geneticist.

I have had the opportunity to have all of my questions answered. I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

____________________________________________  ____________________
Signature of Person Being Tested (or guardian)  Date  

____________________________________________  ____________________
Witness  (rev. 9/7/2011)  Date