CONSENT FOR EMBRYO REDUCTION

- I request embryo reduction from ____ to ____ fetuses.
- I was given sufficient information and time to choose this option. I understand that my options are to continue with the whole pregnancy, have a termination of the whole pregnancy, or have embryo reduction.
- I know that embryo reduction involves an injection into the chest of one or more fetuses, which will result in their death.
- I am aware that the risk of miscarriage after reduction is 5-10% if the initial number of fetuses is three, and 20-50% if the initial number of fetuses is over three.
- I am aware that the risk of severe preterm delivery (24-32 weeks) after reduction is 5-10% if the initial number of fetuses is three, and 15-20% if the initial number of fetuses is over three.
- I am aware that although embryo reduction does not cause damage to the surviving fetuses, it is possible that these fetuses have abnormalities which can not be seen by ultrasound at this stage of pregnancy.
- I am aware that if I develop a high temperature, cramping abdominal pain or vaginal bleeding in the next few days I must contact my hospital immediately.
- I agree / do not agree to give a blood sample for research purposes.
- I agree / do not agree to have my data used for research purposes. In either case, my decision to refuse will not affect my treatment.

Patient _____ ID _____

Signature _____

Doctor _____ Date _____

WELCOME TO OUR CENTRE

The majority of our patients are seen within one hour of arriving. We give opportunity to discuss at length her concerns about her pregnancy.

Patient will receive counselling concerning their options and it is important that she take as much time as she need to reach a decision in favour or against an invasive test. Please feel free to ask any questions and discuss any concerns you may have.

All the preliminary scan will be carried out by me only. I will perform the scan and the invasive procedure.

After patient has left our centre, if there are any unresolved questions, please write to me or contact me and leave a message, I will call you back if required.

Outcome of pregnancy

Outcome information is important for the audit of our service and for our continuing research in fetal medicine. Patient will be given an outcome form and I would be grateful if you would complete and return it to us. We may also need to contact you or your patient or hospital to obtain further details. All information received will be treated as confidential and anonymised data may be used for our research. If you have any objections to this, please let us know during your visit.

Dr. Prashant Acharya
PACFM

PARAS

ADVANCED CENTER FOR FETAL MEDICINE

4D Sonography, Color Doppler & Endoscopy Centre

FETAL CARE I ULTRASOUND
GENETICS I CHEMICAL MARKERS
HIGH RISK OBSTETRICS CARE

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MULTIFETAL PREGNANCY

Fetal Medicine Foundation (FMF, UK) certified Sonographer

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Fetal Medicine Foundation of India

PARAS

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WE HONOUR REFERENCES FOR

- Chorian Biopsy
- Amniocentesis
- Fetal Cordocentesis
- Fetal Reduction
- Amnio infusion / drainage / amniopatch
- Fetal Blood Transfusion
- Fetal Shunt Procedure
- Fetal Liver/Skin/Muscle Biopsy
- Detection of Chromosomal Anomalies
- "Recurrent Pregnancy Loss" - complete evaluation
- Genetic Counseling
- Comprehensive evaluation of Fetus at risk
- Once "USG abnormality detected" - What next?
  (counselling and further management of mother or fetus)

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