PREVENTION GENETICS

DISEASE PREVENTION THROUGH GENETIC TESTING

PRENATAL HEALTH CARE PROVIDER'S STATEMENT*

September 17, 2012

***Note**: **This Statement is required, and applies to all cases of ongoing pregnancy.**

Mother's Name: _____

Date of Birth:_____

My signature below indicates all of the following:

- I take responsibility for the appropriateness of the requested testing.
- I have explained the purpose of the prenatal testing that I have requested.
- I have provided appropriate genetic counseling to my patient.
- I have given the opportunity for the patient to ask questions.
- I am responsible for obtaining written or verbal informed consent (ensuring that my patient understands risks, benefits and limitations of the testing and the implications of the results).

_____ _____

Health Care Provider Signature **Date**

_____

Printed Name

3800 S. Business Park Ave. · Marshfield, WI 54449
Ph: 715.387.0484 · Fax: 715.384.3661
www.preventiongenetics.com