

Amniocentesis and CVS Procedure Record

Woman's identifier (or pre-printed label)
Woman's surname/ family name
Woman's first names
Date of birth
NHS number (or other identifier)
Woman's contact telephone numbers (Home)
(Mobile)
(Work)
Name of community midwife
Place booked for delivery

Information Giving

Diagnostic procedure offered

Amniocentesis Chorionic villus sampling

Reason for offering procedure

Higher chance Down's syndrome screening result

Family history of an inherited disorder

Previous pregnancy with a chromosome disorder

Suspected fetal anomaly found on ultrasound scan

Other

Information giving

Did the woman receive a copy of the ASW:

Amniocentesis leaflet? YES NO

CVS leaflet? YES NO

Date and time **written information** given

Name and designation of person who gave written information

Date and time **verbal information** given

Name and designation of person who gave the verbal information

How was the verbal information given? face to face telephone

Procedure accepted

Amniocentesis Chorionic villus sampling None

Consent

Consent form signed YES NO

Woman given a copy YES NO

Consent form filed in the maternity notes YES NO

Signature

Date

Name (PRINT)

Job title

Results handling

Results handling discussed with the woman pre procedure YES NO

The woman has been informed that the information may be used for audit purposes YES NO

Agreed method of giving results

Telephone Letter Home visit Antenatal clinic

Other

Other contact information

Name and designation of person who received the PCR result from the genetic laboratory

Name and designation of person who received the karyotype result from the genetic laboratory

Date and time **PCR result** given to the woman

Signature

Name (PRINT)

Date and time **karyotype result** given to the woman

Signature

Name (PRINT)

Date pregnancy outcome form completed and returned to the cytogenetics laboratory

Procedure

Procedure	
Gestation at procedure	
Name of hospital where procedure performed	
Date and time of procedure	
Name and designation of operator or supervisor	
Name and designation of trainee operator	
Pre procedure scan	Live fetus <input type="checkbox"/> YES <input type="checkbox"/> NO
Post procedure scan	Live fetus <input type="checkbox"/> YES <input type="checkbox"/> NO
Position of the placenta	anterior / posterior / fundal / low / high
Uterus position	AV / RV / Axial
Scan performed by	
Skin preparation in accordance with local infection control protocols	<input type="checkbox"/> YES <input type="checkbox"/> NO
Direct scan control throughout procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sterile gel used	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sterile probe cover used	<input type="checkbox"/> YES <input type="checkbox"/> NO
Use of echo tip needle	<input type="checkbox"/> YES <input type="checkbox"/> NO
Number of uterine insertions	
Reason for repeated insertions	
Number of needles used	
Amniocentesis	CVS
	Local anaesthetic used <input type="checkbox"/> YES <input type="checkbox"/> NO Please specify
Needle used 20g / 21g / 22g	Needle used 20g / 18g / 17g / 16g other Double needle used <input type="checkbox"/> YES <input type="checkbox"/> NO 17/19 gauge or 18/21 gauge
Length of needle 9cm / 15cm	CVS method of aspiration used syringe / suction / other
Transplacental route <input type="checkbox"/> YES <input type="checkbox"/> NO	Route <input type="checkbox"/> TA <input type="checkbox"/> Other please specify
Amniotic fluid quantity ml	Sufficient placental sample obtained <input type="checkbox"/> large <input type="checkbox"/> medium <input type="checkbox"/> small
AF colour clear / blood stained If blood stained old / fresh	
Fetal heart	
Bradycardia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rate per min	

Difficult procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO
Specify location of bleeding	
Contractions	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fetal contact during procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other comments	

Sample	
Sample label checked with the woman on completion of the procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO

Maternal Rhesus status	
Rhesus	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
Dose of Anti D given	
Kleihauer performed	<input type="checkbox"/> YES <input type="checkbox"/> NO

Signature of operator	
Signature	Date
Name (PRINT)	
Job title	

Sample transport arrangements	
Courier – date and time of sample given to courier	
Sample taken to laboratory by	
Transport department reference number	
Other	
Cytogenetic laboratory informed that the sample is in transit	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sample packed according to requirements of UN packaging instruction P650	<input type="checkbox"/> YES <input type="checkbox"/> NO

Complications	
Premature rupture of membranes	Date
Membrane separation / Retroplacental haematoma	Date
Other comments	