AMNIOCENTESIS or CHORIONIC VILLOUS SAMPLING (CVS) CHECKLIST

PRIOR TO PROCEDURE

☐ Genetic Counseling completed
☐ Indication for procedure documented
☐ Review of History, Medications, and Imaging
☐ Review of Available Labs
  _ Rh status
  _ Antibody Screen
  _ HIV
  _ Hepatitis B
  _ Hepatitis C (if appropriate)
  _ 1st trim. Gonorrhea/Chlamydia (CVS only)
  _ Additional center-specific labs _________
  ______________________________________

☐ Planned Genetic Test(s)
  _ Karyotype
  _ Chromosomal microarray
  _ FISH
  _ Molecular / Biochemical (eg. AFP, 7-DHC)
  _ Other (eg. infection studies)
  ______________________________________

☐ Specialty Tests or Instructions
  _ Maternal cell contamination requested
  _ Sample size requested
  _ Specialty Lab send out
  _ Special handling requested

PRE-PROCEDURE TIME OUT

☐ Confirm identity of patient
☐ Confirm procedure to be performed
☐ Validate correct identification on signed consent and specimen labels
☐ Review relevant allergies (e.g. betadine, chlorhexidine, latex, local anesthesia)
☐ Planned sample, sample size, and intended tubes
☐ Multifetal gestations: appropriate labeling of trays/tubes

AFTER PROCEDURE

☐ Physician reviews specimen labeling with patient
☐ Multifetal gestations: appropriate documentation of sac/placenta locations (diagram if applicable)
☐ Patient received post procedure instructions (warning symptoms, contact information)

Assess Rh D immune globulin need (select one)

☐ Rh POS: **Rh D immune globulin not indicated**
☐ Rh NEG: **Rh D immune globulin given**
☐ Rh NEG, FOB Rh NEG (certain paternity): **Rh D immune globulin not indicated**
☐ Rh NEG, but Rh(D) alloimmunized, **Rh D immune globulin not indicated**

NOTES

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