

Print Patient Name: _____

Insurance Coverage of Ultrasounds

I have read and understand the information regarding my financial responsibility for associated ultrasound costs if not covered by my insurance.

Patient Signature _____
Date

Consent for Cystic Fibrosis/SMA/Fragile X Carrier Blood Test

I have read and understand the information regarding carrier blood testing, and accept financial responsibility for any associated costs that are not covered by my insurance. Initial One:

_____ I CONSENT to the Carrier Testing _____ I DECLINE the Carrier Testing

Patient Signature _____
Date

Consent for Genetic Screening

I have read and understand the information regarding Nuchal Translucency and Blood Testing. I also accept financial responsibility for any associated costs that are not covered by my insurance. Initial One:

_____ I CONSENT to the Nuchal Translucency and Blood Testing. _____ I DECLINE to the Nuchal Translucency and Blood Testing

Patient Signature _____
Date

Please circle one:

- YES NO Will you be 35 years or older at your due date?
- YES NO Have you had alcohol (beer,wine,liquor) during your pregnancy?
- YES NO Have you used any drugs (cocaine, marijuana, etc) during your pregnancy?
 If so what: _____
- YES NO During your pregnancy have you taken Acutance or epilepsy medication?
- YES NO During your pregnancy have you taken blood thinners or Lithium?
- YES NO Have you had radiation therapy or chemotherapy since your last period?
- YES NO Are you diabetic?
- YES NO Are you and your partner related in any way (other than marriage)?
- YES NO Do you or your partner have a history of genital herpes?
- YES NO Do you or your partner have a history of HIV or Hepatitis B or C?
- YES NO Have you taken any medications (prescription or OTC) during your pregnancy?
 If so what: _____

Have you OR your partner, OR anyone in either family ever had:

(please answer in all three columns)

	MYSELF	PARTNER	EITHER FAMILY
A child with Down Syndrome or other chromosome problems?	Y N	Y N	Y N
A child with mental retardation?	Y N	Y N	Y N
Open Spine (Spina Bifida), skull defect or Anencephaly?	Y N	Y N	Y N
Heart defect?	Y N	Y N	Y N
Muscle or neuromuscular disease (Muscular Dystrophy)?	Y N	Y N	Y N
A stillborn baby?	Y N	Y N	Y N
A baby that died shortly after birth or within the first year?	Y N	Y N	Y N
Cystic Fibrosis?	Y N	Y N	Y N
Hemophilia, Sickle Cell, Thalassemia, or other blood disorder?	Y N	Y N	Y N
Any birth defect or genetic disorder?	Y N	Y N	Y N