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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