PLEASE READ, COMPLETE AND BRING FORM WITH YOU FOR YOUR FIRST OFFICE VISIT

Name _____ D.O.B._____

During your pregnancy, there is testing available to screen for **chromosomal abnormalities** (e.g. Down syndrome), **inherited diseases** (e.g. cystic fibrosis), and/or **other abnormalities** (e.g. spina bifida). None of these tests are required.

You will need to check with your insurance regarding what testing is covered under your insurance. We have included CPT codes next to each testing option to assist in your communication with your insurance company.

The questions on the back will help us determine your risk and need for testing. A consultation with a high-risk obstetrician in Louisville (Maternal Fetal Medicine) may be discussed and depends on your risk factors.

All testing options at our office are performed by just drawing blood from your arm.

SECOND TRIMESTER 'QUAD' test (82105, 84702, 82677, 86336)- It detects up to 60-80% of open neural tube defects (e.g. spina bifida), Down Syndrome, and Trisomy 18. Performed between **16 and 20 weeks**.

CYSTIC FIBROSIS or 'CF' (81220)- One of the most common inherited disorders in the United States. All babies after birth are routinely checked for CF. Performed **at any time** during your pregnancy.

NIPS : Non Invasive Prenatal Screening (81420)- Usually for higher risk pregnancies. It detects 87-99% of genetic disorders (e.g. Down Syndrome and others). Performed only **after 10 weeks**. This does NOT check for spina bifida. You will still need the spina bifida test **("AFP")** done **between 16-20 weeks** if desired.

PLEASE READ, COMPLETE AND BRING FORM WITH YOU FOR YOUR FIRST OFFICE VISIT

Name _____ D.O.B._____

GENETIC SCREENING QUESTIONS

These questions apply to ***you***, **the *baby's father***, and **anyone in *either family***.

1. How old will you be when your baby is born? _____		
2. Are there multiple births (twins, triplets, etc.)?	No	Yes
3. Is there any Jewish background?	No	Yes
4. Has a doctor told you there is a genetic/chromosomal (e.g. Down Syndrome) or inherited problem (e.g. cystic fibrosis) in either family?	No	Yes
5. If you are African American, do you have sickle cell trait or disease?	No	Yes
6. Are there any children with birth defects (e.g. spina bifida/open spine, hydrocephalus/water on the brain, heart defect)?	No	Yes
7. Are there any children on a special diet (e.g. diabetes, PKU)?	No	Yes
8. Does anyone have problems with their muscles, such as weakness, or problems walking, Duchenne's or any muscular dystrophy?	No	Yes
9. Does anyone suffer from mental retardation or mental slowing, slow to grow/develop, or slow to walk/talk?	No	Yes
10. Have any women had stillborn babies, babies that died shortly after birth, or had at least 2 miscarriages?	No	Yes
11. Is there anyone who is a free bleeder/hemophiliac or has thalassemia?	No	Yes
12. Are there any family health problems that you are worried your baby might have?	No	Yes
If you need blood products as a medical necessity, will you accept them?	**No**	**Yes**

Patient Signature_____Date_____

Provider Signature_____Date_____