

## Prenatal Genetic Screening

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Genetic Screening/ Teratology Counseling  
(Includes patient, baby's father or anyone in either family with: )

1. Patient's age greater than 35 years as of estimated date of delivery

Y                      N

If you answer Y (yes) to question #1, we recommend high risk counseling with a Perinatal Specialist to help you decide on further testing, such as first trimester screening, ultrasound or amniocentesis. First trimester screening includes free Beta, PAPP-A and nuchal translucency.

I **accept** high risk counseling. Please schedule an appointment for me. **Initials** \_\_\_\_\_

I **decline** high risk counseling. **Initials** \_\_\_\_\_

2. Thalassemia (Italian, Greek, Mediterranean or Asian background): MCV < 80

Y                      N

3. Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)

Y                      N

4. Congenital Heart Disease

Y                      N

5. Down's Syndrome

Y                      N

6. Tay-sachs (Jewish, Cajun, French Canadian)

Y                      N

7. Sickle Cell Disease/ Trait

Y                      N

8. Hemophilia or other blood disorder

Y                      N

9. Muscular Dystrophy

Y                      N

10. Cystic Fibrosis

Y                      N

11. Huntington's Chorea

Y                      N

12. Mental Retardation/ Autism

Y                      N

13. Other inherited genetic or chromosomal disorder

Y                      N

14. Maternal Metabolic Disorder (Type I Diabetes, PKU)

Y                      N

15. Patient or baby's father had a child with birth defects not listed above

Y                      N

16. Recurrent pregnancy loss or greater than 2 stillbirths

Y                      N

My signature certifies that the above information is accurate and true to the best of my knowledge.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(Parent if minor)