



PRENATAL QUESTIONNAIRE

Please fill this questionnaire out to the best of your ability:

DATE : _____ / _____ / _____

NAME LAST: _____ MIDDLE: _____ FIRST: _____				BIRTHDATE _____		AGE _____		RACE _____		MARITAL STATUS _____					
ADDRESS: _____ CITY, STATE, ZIP: _____															
OCCUPATION _____						PHONE (C) _____			(H) _____			(O) _____			
EDUCATION _____															
HUSBAND/FATHER OF BABY _____						PHONE _____			EMERGENCY CONTACT _____			PHONE _____			
TOTAL # OF PREGNANCIES _____		FULLTERM _____		PREMATURE _____		AB. INDUCED _____		AB. SPONTANEOUS _____		MULTIPLE BIRTHS _____		ECTOPICS _____		LIVING _____	

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD _____				DEFINITE _____				APPROXIMATE (MONTH KNOWN) _____				MENSES MONTHLY? _____				YES _____		NO _____	
MENARCHE _____				(AGE ONSET) _____				UNKNOWN _____				ON BIRTHCONTROL AT CONCEPTION? _____				YES _____		NO _____	

PAST PREGNANCIES (LAST SIX)

DATE	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

PAST MEDICAL HISTORY

	0 NEG + POS	DETAILS FOR POSITIVE MARKS INCLUDE DATE & TREATMENT		0 NEG + POS	DETAILS FOR POSITIVE MARKS INCLUDE DATE & TREATMENT
DIABETES			D (Rh) SENSITIZED		
HYPERTENSION			PULMONARY (TB, ASTHMA)		
HEART DISEASE			ALLERGIES (DRUGS)		
AUTO IMMUNE DISORDER			BREAST		
KIDNEY DISEASE / UTI			GYN SURGERY		
NEUROLOGIC / EPILEPSY					
PSYCHIATRIC					
HEPATITIS /LIVER DISEASE			OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
VARICOSITIES / PHLEBITIS					
THYROID DYSFUNCTION					
TRAUMA / DOMESTIC VIOLENCE			ANESTHETIC COMPLICATIONS		
HISTORY OF BLOOD TRANSFUSION			HISTORY OF ABNORMAL PAP		
	AMT / DAY PRE PREG	AMT / DAY PRE PREG	# YEARS OF USE	UTERINE ANOMALY / DES	
TOBACCO				INFERTILITY	
ALCOHOL				RELEVANT FAMILY HISTORY	
STREET DRUGS				OTHER	

TO THE BEST OF YOUR KNOWLEDGE, DO YOU OR ANYONE IN YOUR FAMILY IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING?

	YES	NO		YES	NO
PATIENT'S AGE (35 OR OLDER)			SPECIAL NEEDS/AUTISM		
THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND) MCV<80			IF YES, WAS PERSON TREATED FOR FRAGILEX?		
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
CONGENITAL HEART DEFECT			MATERNAL METABOLIC DISORDER (EG. INSULIN DEPENDENT DIABETES, PKU)		
DOWN SYNDROME			PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
TAY-SACHS (EG. JEWISH, CAJUN, FRENCH, CANADIAN)			RECURRENT PREGNANCY LOSS OR A STILL BIRTH		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)			MEDICATIONS / STREET DRUGS / ALCOHOL SINCE LAST MENSTRUAL PERIOD		
HEMOPHILIA			IF YES, AGENT (S)		
MUSCULAR DYSTROPHY					
CYSTIC FIBROSIS			ANY OTHER		
HUNTINGTON CHOREA					

COMMENTS:

INFECTION HISTORY	YES	NO		YES	NO
HIGH RISK HEPATITIS B / IMMUNIZED?			RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			HISTORY OF STD / GC / CHLAMYDIA / HPV / SYPHILLIS		
PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			OTHER		

BLOOD TRANSFUSION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE-THREATENING SITUATION?			



Consent for Prenatal Testing

**Please read and initial each testing description.
Sign the last page.
Your provider will answer any questions you
have during your visit.**

Prenatal care involves both routine and optional tests evaluating the mother and the baby. The purpose of this document is to inform you of the required, routine tests as well as to inform you of the optional tests recommended by our practice. If you have any questions, please ask your provider.

Required Tests for All Patients include:

_____ **Patient initials**

- | | | |
|-------------------------|------------------------------|--------------------------------|
| · Blood type | · Antibody screen | · Complete blood count |
| · Group B Strep culture | · HIV | · Rubella |
| · Syphilis | · Hepatitis B | · Hepatitis C |
| · Urine culture | · Hemoglobin electrophoresis | · Gonorrhea/Chlamydia |
| · Pap smear | · Varicella | · Gestational Diabetes Testing |
| · Anatomy ultrasound | | |

Obstetric Ultrasound Examination Consent:

_____ **Patient initials**

Ultrasound is a medical diagnostic procedure for the purpose of aiding your physician in determining your best course of treatment. Ultrasounds are most commonly done in pregnancy to provide an accurate due date, locate the placenta, identify multiple gestation pregnancy, identify malformations of the fetus, monitor fetal growth, identify fetal position, evaluate amniotic fluid levels, monitor for fetal well-being, and may be used to identify the fetal gender.

Some ultrasounds are routinely performed in pregnancy, and most pregnancies will have a total of three ultrasounds. First, early in the first trimester to evaluate for accurate due date. Second, at the start of sequential screening to identify malformations and risk for chromosomal abnormalities. Third, perform a more detailed fetal anatomic evaluation.

Further ultrasounds may be recommended by your doctor depending on higher risk issues or concerns identified during your prenatal care. An ultrasound may be recommended to evaluate and monitor the fetal' growth and well-being. If you do not have these ultrasounds as recommended, you may be putting you and your fetus at harm. Failure to have an ultrasound done as recommended may make it difficult, if not impossible, to provide appropriate care for you and your pregnancy in the best way possible.

Ultrasound is an extremely safe modality and has never been known to cause harmful fetal effects after decades of clinical use. Ultrasound is not an X-ray and has no radiation. The ultrasound transducer/wand produces a small burst of high frequency sound and then listens for the "echo" of the sound in your body. A computer then integrates this information to make the picture that you see on the screen.

The quality of ultrasound examinations is extremely dependent on many factors. Ultrasound is not a perfect science, and it is possible that fetal birth defects which are present may not be seen or may be falsely reported during an obstetrical ultrasound. Neither a normal ultrasound exam, nor the results of any other prenatal test, guarantees a normal, healthy baby. Not all abnormalities may be identified on ultrasound.

Recommended Screening Tests:

These are recommended, but optional, screening tests. These are screening tests, **NOT** diagnostic tests. Abnormal results require confirmation with diagnostic testing such as chorionic villous sampling (CVS) or amniocentesis. The tests have limitations, including the possibility of false positives, false negatives, and inconclusive results. Insurance coverage of these tests may vary. We encourage you to contact your insurance company to determine your patient responsibility before having the tests performed. It is the patient's responsibility to verify their coverage. Please see the attached patient resource page to help determine these costs.

Natera Horizon Carrier Screening Test:

_____ I accept testing _____ I decline testing

If testing accepted, I choose to: _____ Self Pay _____ Bill Insurance

The Horizon 14 carrier screening test is a screening test that maternal blood to assess the risk of certain chromosomal conditions including autosomal recessive and X-linked conditions. This screening assesses maternal carrier status for Cystic Fibrosis, Spinal Muscular Atrophy, Alpha Thalassemia, Fragile X syndrome, and other inheritable conditions. A positive carrier screening test identifies a person who is a carrier for a specific genetic disease. Your partner must be a carrier for the same disease for you to be at risk for having an affected child, with the exception of X-linked disorders. For X-linked disorders, carrier screening is offered only to women, as only female carriers are at risk to have children affected with an X-linked disorder. Genetic counseling and recommendations regarding partner testing will be discussed as needed.

Choose ***EITHER*** Natera Panorama Prenatal Screening Test ***OR*** PathGroup Sequential Screening.

Natera Panorama Prenatal Screening Test:

_____ I accept testing _____ I decline testing

If testing accepted, I choose to: _____ Self Pay _____ Bill Insurance

The Natera Panorama Screening Test is a blood test that looks at the fetal DNA found in the mother's bloodstream and is not harmful to the fetus in any way. This screening test helps determine if your baby is at risk for a number of chromosomal abnormalities including Down syndrome, Edwards syndrome, Patau syndrome and sex chromosome abnormalities. Panorama can also assess the likelihood that your baby has a condition linked to a few selected microdeletions of its chromosomes. This test is performed at any point after 10 weeks. This test has a detection rate of 99% for trisomy 21, with a false positive rate of 0.1-0.3%.

PathGroup Sequential Screening:

_____ I accept testing _____ I decline testing

If testing accepted, I choose to: _____ Self Pay _____ Bill Insurance

The PathGroup Sequential Screening is a non-invasive screening method to identify the risk of the fetus having Down Syndrome, Trisomy 18, or neural tube defects. These tests do not tell whether the fetus actually has these disorders. If the initial screening is positive, further diagnostic testing would be offered to identify if the baby actually has these disorders. Sequential screening consists of an ultrasound at approximately 12 weeks and bloodwork on the mother at approximately 12 weeks and again at approximately 16-18 weeks. This test is not harmful to the fetus in any way. It has a 95% detection rate for Down Syndrome and a 5% false positive result.

I have had the opportunity to review this information and ask questions.

Date: ____/____/____

Patient Name: _____

Patient Signature: _____

Counseled by and questions answered:

Physician/Midwife Signature: _____

CONSENT FOR HIV TESTING

Please initial your choice and sign below:

 I authorize the practice to test me for HIV, the virus that causes Acquired Immunodeficiency Syndrome (AIDS) and related syndromes.

In signing this consent form, I acknowledge that I have been provided with information about this test, about the HIV virus and all of my questions regarding such have been answered.

I have been informed that both my request for the HIV test and the test result is considered confidential and will be released to only me except as required or permitted by law.

If the test results are positive, I will be provided with information about the consequences for my own health care so that I might take precautions to prevent transmission of the virus by law.

I understand that Georgia law requires the reporting of a confirmed positive test results to the Public Health Department.

I understand that, unless otherwise limited by state and federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

 I do not authorize blood collection for the HIV antibody testing.

I understand that in declining testing in the state of Georgia, an unknown HIV status of a newborn may result in the baby being treated with medications prophylactically as positive, until it is proven negative.

_____ DOB: ____/____/____

Signature of Patient

Date ____/____/____

_____ Date ____/____/____

Signature of Witness/Staff Member

I have consulted with the above named patient about testing her for HIV, and about the availability and necessity of post-testing counseling and advised that the test results will be handled confidentially as prescribed by law.

_____ Date ____/____/____

Signature of Physician or Midwife

Patient Resource Page for Prenatal Screening Options:

- Due to the complexity of coverage guidelines, we are unable to quote benefits or guarantee insurance coverage for any of these tests.
- You are encouraged to contact your insurance company to obtain your benefits based on your age and risk factors, so that there are no surprises. Insurance benefits are plan-specific and offer vastly different coverage based on your policy. ***Even if the testing is covered, it could be applied to any unmet deductibles, and copays may apply, resulting in a large bill.***
- The laboratories will bill you separately for any testing. We are unable to answer any billing questions regarding these tests. Any questions regarding billing for labs/bloodwork can only be addressed by the lab.
- ***Please note – Once a decision has been made regarding billing (self-pay vs bill insurance), it cannot be changed. All decisions must be finalized at the time of testing.***

Natera Panorama Prenatal Screening Test (Genetic Testing only) and Horizon Carrier Test (Genetic Testing + Advanced Carrier Testing, including CF)

- These labs are billed through **Natera**.
- Call your Member Services number on the back of your insurance card to speak with a representative regarding your patient responsibility. Provide them with the CPT codes below, based on the testing you have selected:
 - Panorama Basic:** 81420
 - Horizon 14:** 81220, 81329, 81257, 81361
- Ask “Is this a covered test during pregnancy?” and “What would be my patient responsibility?”
- The Panorama/Horizon test is most often covered by insurance, and approximately 2/3 of in-network patients have no out-of-pocket (OOP) cost. Depending on your insurance plan, you may still have some OOP cost even when insurance covers testing.
- If you choose to use insurance, keep in mind that insurance benefits are plan-specific and offer vastly different coverage based on your policy. ***Even if the testing is covered, it could be applied to any unmet deductibles and copays, resulting in a large bill.***
- If you choose to not use your insurance (you choose to pay for the labs as “self-pay”), the cost of the Panorama test is \$249 and the cost of the Horizon test is \$99 billed by and paid directly to Natera
- All billing for the Panorama/Horizon tests is handled by Natera. If you have any questions, please call their Customer Service Billing Department at **(877) 869-3052** to speak with a Natera representative.

Cystic Fibrosis (CF only)

- This lab is billed through **PathGroup**.
- Call your Member Services number on the back of your insurance card to speak with a representative regarding your patient responsibility. Provide them with the CPT code 81220
- Ask “Is this a covered test during pregnancy?” and “What would be my patient responsibility?”
- If you choose to use insurance, keep in mind that insurance benefits are plan-specific and offer vastly different coverage based on your policy. ***Even if the testing is covered, it could be applied to any unmet deductibles, and copays may apply, resulting in a large bill.***
- If you choose to not use your insurance (you choose to pay for the lab as “self-pay”), the cost of the lab is \$159 billed by and paid directly to PathGroup.
- All billing is handled by PathGroup. If you have any questions, please call their Customer Service Billing Department at **(888)656-6054** to speak with a PathGroup representative.

Sequential Screen

- It is not advised to have this blood test done if you are choosing to have the Panorama/Horizon test done. If you choose not to do Panorama or Horizon, we do recommend doing the Sequential Screen

- Call your Member Services number on the back of your insurance card to speak with a representative regarding your patient responsibility. Provide them with the CPT lab codes 81508, 81511, 82677, 82105, 86336
- Ask “Is this a covered test during pregnancy?” and “What would be my patient responsibility?”
- If you choose to use insurance, keep in mind that insurance benefits are plan-specific and offer vastly different coverage based on your policy. ***Even if the testing is covered, it could be applied to any unmet deductibles, and copays may apply, resulting in a large bill.***