MODERN
OBSTETRICS & GYNECOLOGY
of North Atlanta, P.C.

PRENATAL QUESTIONNAIRE

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

NAME LAST: _____ FIRST: _____ MIDDLE: _____ DATE :_____/_____/_____

BIRTHDATE AGE RACE MARITAL STATUS	ADDRESS
OCCUPATION EDUCATION	PHONE (C) (H) (O)
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

	O NEG + POS	DETAILS FOR POSITIVE MARKS INCLUDE DATE & TREATMENT		O 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		

ANTEPARTUM

TO THE BEST OF YOUR KNOWLEDGE, DO YOU OR ANYONE IN YOUR FAMILY IMMEDIATELY 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, SPINABIFIDA, 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 / ALOCHOL 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 TRANSFUION/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?			

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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
- HIV
- Anatomy ultrasound
- Gonorrhea/Chlamydia
- Antibody screen
- Rubella
- Glucose testing
- Pap smear
- Complete blood count
- Syphilis
- Urine culture
- Group B Strep culture
- Hepatitis B
- Hemoglobin evaluation

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, to 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 are 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. 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 with determining these costs.

Cystic Fibrosis Screening:

_____ I accept testing _____ I decline testing

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

Cystic fibrosis is a genetic disorder that causes breathing and digestive problems and results in a shorter life span. Intelligence is not affected by CF. CF is an inherited condition when a mother and her partner are both carriers of the CFTR gene. CF screening allows us to identify if a mother is a carrier of the gene. If she does carry the gene, then partner testing is recommended. The risk of being a carrier depends on an individual's race and ethnicity and family history. This disease occurs most commonly in non-Hispanic, white individuals and people of Ashkenazi Jewish ancestry. However, it is reasonable to offer CF carrier screening to all patients due to the difficulty in assigning a single ethnicity.

*Choose **EITHER** Sequential Screen **OR** Non-Invasive Prenatal Screen for fetal genetic chromosome screening:*

Claritest Core TH18 - Core Non-Invasive Prenatal Testing (NIPT):

_____ I accept testing _____ I decline testing

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

The Claritest Core TH18 Non-Invasive Prenatal Screen (NIPS) is a blood test that looks at 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 increased risk for a number of chromosomal abnormalities including Down syndrome, Edwards syndrome, Patau syndrome and sex chromosome abnormalities. NIPT 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 detects more than 99 in 100 cases of Down syndrome and has a low false positive rate of less than 1 in 1,600.

Sequential screening:

_____ I accept testing _____ I decline testing

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

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 test is positive, further diagnostic testing would be offered to identify if the baby actually has these disorders. Sequential screening consists of 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 opportunity to review this information and to 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 results are 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 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:_____/_____/20_____

_____ Date:_____/_____/20_____

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:_____/_____/20_____

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.
- 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 bill.
- 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.
- The laboratories will bill you separately for any testing.

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Claritest Core TH18- Non-Invasive Prenatal Testing (NIPT)

- This lab is billed through BioReference Laboratories
- **Call 1-833-469-5227** to speak with the Customer Service Billing Department
- **OR visit www.genpathdiagnostics.com/costestimator** to obtain your personalized out-of-pocket estimate. You can also scan the QR code to be directly linked to the above website.
- These patient care specialists will help you determine if this is a covered test under your insurance and what your patient responsibility cost may be
- The Claritest Core TH18 is most often covered only by insurance for "high risk patients" (age >35 yrs old, or other high risk genetic factors)
- If you choose to not use your insurance (you choose to pay for the labs as "self-pay"), the cost of the test is $249 billed by and paid directly to BioReference Laboratories.

Cystic Fibrosis

- This lab is billed through PathGroup
- Call your Member Services number on the back of your insurance card to speak with a representative
- Provide them with CPT code 81220
- Ask "Is this a covered test during pregnancy?"
- Ask "What would be my patient responsibility?"
- 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.

Sequential Screen

- It is not advised to have this blood test done if you are choosing to have the Claritest Core TH18 test done
- If you choose not to do Claritest Core TH18, we do recommend doing the Sequential Screen
- Call your Member Services number on the back of your insurance card to speak with a representative
- Provide them with CPT lab codes 84163, 84702, 82677, 82105, 86336
- Ask "Is this a covered test during pregnancy?"
- Ask "What would be my patient responsibility?"