BLOOM OB/GYN

Preconception Genetic Questionnaire and Consent Form

Name: _____ Date of Birth _____ Age: _____

Partner Name: _____ Date of Birth _____ Age: _____

1. Do you, your partner, or anyone in your families have any of these disorders?

Cystic Fibrosis	**Yes/No**	Polycystic Kidney Disease	**Yes/No**
Muscular Dystrophy	**Yes/No**	Neural tube defect (open spine)	**Yes/No**
Hemophilia	**Yes/No**	Neurofibromatosis	**Yes/No**
Huntington's disease	**Yes/No**	Marfan syndrome	**Yes/No**

If yes, please indicate the relationship of the affected person to you or your husband: _____
_____

2. Do you or your partner have a birth defect or familial disorder not listed above? **Yes/No**

If yes, please specify: _____

3. Do you or your partner have a close relative with mental retardation, autism, any birth defect, Fragile X, familial disorder, or a chromosome disorder such as Down Syndrome? **Yes/No**

If yes, please specify the condition and indicate the relationship: _____

4. In any previous marriage(s) have you or your partner had a child born with a birth defect or had a pregnancy or child diagnosed with Down Syndrome? **Yes/No**

If yes, please specify the defect: _____

5. Have you or your partner in this or any previous marriage had a stillborn child, a second or third trimester pregnancy loss or two or more first trimester miscarriages? **Yes/No**

If yes, please specify: _____

6. Did you or your partner have carrier testing for:

Cystic Fibrosis: **Yes/No** Spinal Muscular Atrophy (SMA): **Yes/No** Fragile X: **Yes/No**

If yes, please indicate results and state who was tested: _____

7. Are you or your partner of Eastern European (Ashkenazi) Jewish, French-Canadian or Cajun ancestry? **Yes/No**

Have you been screened for Tay-Sach's disease? **Yes/No**

If Eastern European Ashkenazi Jew, have you been screened for any of the other conditions that are common amongst Ashkenazi Jews? **Yes/No**

If yes, please indicate the results and who was tested: _____

8. Are you or your partner of Afro-American, Hispanic, or Caribbean ancestry? **Yes/No**

Have you been screened for sickle cell trait? **Yes/No**

If yes, please indicate the results and who was tested: _____

9. Are you or your partner of Mediterranean (Italian, Greek, North African), Asian (Chinese, Indian, or Pakistani), South East Asian (Taiwanese, Vietnamese), or Middle Eastern (Iranian, Turkish, or Egyptian) background? **Yes/No**

Have you ever been screened for Thalassemia (alpha or beta)? **Yes/No**

If yes, please indicate results and who was tested: _____

I have completed the "Preconception Genetic Questionnaire" and answered the questions to the best of my knowledge.

Based on my answers the following tests were recommended:

_____ A. I/We agree/decline (please circle) the recommended test(s) at this time

_____ B. Reason(s) for declining the recommended test(s) are as follows: _____

_____ C. A consideration for genetic counseling has been offered to us and we accept/decline (please circle) at this time

We/I understand:

1) The test(s) is/are for an abnormality in the genes for the disorder(s), using DNA analysis.

2) The purpose of testing is to determine a carrier status (unaffected but able to pass the abnormal gene onto a child by inheritance)

3) The test(s) is/are for genetic susceptibility ("genetic predisposition") and that the risk of having the disorder(s) may be altered by family history and/or other factors. If the test(s) is/are positive for the disorder(s) or for an increased risk of the disorder(s), you may wish to have further independent testing or have genetic counseling.

4) Negative testing does not completely eliminate the likelihood of conceiving a child with that particular genetic abnormality. Genetic testing should be considered a tactic to reduce risk but cannot always completely eliminate the likelihood of disease. One explanation is occurrence of new or spontaneous mutations. Another is that testing is not done for every mutation that can occur within any particular gene (whether currently known or unknown).

5) The results of the above test(s) become a part of your medical record and may be made available to individuals/organizations with legal access to your medical record, on a strict "need-to-know" basis, including, but not limited to physicians and nursing staff directly involved in your care, your current and future insurance carriers, and others specifically authorized by you to gain access to the medical record.

6) Your medical insurance may not pay for the test; in which case, you will be responsible for the bill. Patient/Wife's

Patient Signature _____ Date: _____

Physician Signature _____ Date: _____