BLOOM OB/GYN

Preconception Questionnaire and Genetic Testing 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 the following disorders? (Please circle all that apply)

Autosomal Dominant Condition	Down Syndrome	Muscular Dystrophy
Autosomal Recessive Condition	Fragile X	Polycystic Kidney Disease
Autism	Heart Defect	Neural Tube Defect (open spine)
Birth Defect	Hemophilia	Neurofibromatosis
Chromosomal Abnormality	Huntington's disease	Sickle Cell Trait/Disease
Cleft Palate or Cleft Lip	Marfan Syndrome	Tay Sachs
Cystic Fibrosis	Mental Retardation	Thalassemia

Please indicate the relationship of the affected person to you or your partner: _____

_____

_____

2. In any previous relationships 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:

_____

_____

3. Have you or your partner in this or any previous relationships had a stillborn child, a child who died shortly after birth, a second or third trimester pregnancy loss or two or more first trimester miscarriages? **Yes/No**

If yes, please specify: _____

_____

4. Have you or your partner previously had carrier screen testing? **Yes/No**

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

_____

5. Please list all prescribed or over-the-counter medications and/or supplements and/or topical creams/lotions that you are currently taking or using:

_____

_____

_____

_____

6. If you have been pregnant before, have you had any of the following: (Please circle all that apply)

Cesarean Section

Chromosomal Abnormality

Gestational Diabetes

Miscarriage

Preterm Birth (<37 weeks gestation)

Preeclampsia

Pregnancy Induced Hypertension

Short Cervix

Stillbirth

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

I/we 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.