ASCREENCRIT

Ambulatory Care/Women's Services
Prenatal Genetic Screening

Form Origination Date: 2/11
Version: 1 Version Date: 2/11

Patient Name ______________________
MRN ______________________
PATIENT IDENTIFICATION LABEL

Patient Name ______________________

1. What is your due date? ______________________
2. What is your occupation / job? ______________________
3. What is your partner's occupation / job? ______________________
4. Have you, the father of the baby, or anyone in either of your families had:

   a. Down Syndrome, mental retardation, or slowness? ☐ Yes ☐ No
   b. Spina Bifida (open spine) or anencephaly (open head)? ☐ Yes ☐ No
   c. Hemophilia (free bleeding)? ☐ Yes ☐ No
   d. Muscular Dystrophy? ☐ Yes ☐ No
   e. Hydrocephalus (water on the brain)? ☐ Yes ☐ No
   f. Cystic Fibrosis (genetic lung disease)? ☐ Yes ☐ No
   g. Neurological disorders (including seizures)? ☐ Yes ☐ No
   h. Deafness or blindness? ☐ Yes ☐ No
   i. Sickle Cell Anemia or Thalassemia? ☐ Yes ☐ No
   j. Any other birth defect (even one surgically corrected)? ☐ Yes ☐ No
      Explain ______________________
      ____
   k. Any other inherited problem? ☐ Yes ☐ No
      Explain ______________________
      ____

5. Are you or is the father of the baby:

   a. African American, Caribbean Hispanic or East Indian? ☐ Yes ☐ No
      If yes, have either of you been screened for sickle cell trait? ☐ Yes ☐ No
   b. Jewish (Ashkenazic/Eastern European), French-Canadian, or Cajun? ☐ Yes ☐ No
      If yes, have either of you had Tay-Sachs carrier screening? ☐ Yes ☐ No
   c. Italian or Greek? ☐ Yes ☐ No
      If yes, have either of you had Thalassemia carrier testing? ☐ Yes ☐ No

6. Have you taken any medication or street drugs since becoming pregnant? ☐ Yes ☐ No
   (Do not include vitamins, iron, or acetaminophen [Tylenol®])

   If YES, please list: ______________________

Completed by: ______________________ Date: __________

Reviewed by: ______________________ Date: __________ Time: _________