235 Plain Street
Providence, RI
Ph: (401) 421-1710
Fax: (401) 861-2164

PRENATAL GENETIC SCREEN DATE: ___________________

Name: _______________________________________D.O.B.____________________

1. Will you be 35 years or older when the baby is due?

2. Have you, the baby's father or anyone in either of your families ever had the following disorders?

Down Syndrome	Yes	No
Other chromosomal abnormality	Yes	No
Neural tube defect, i.e. Spina Bifida	Yes	No
Hemophilia	Yes	No
Sickle cell anemia	Yes	No
Cystic Fibrosis	Yes	No
Thalassemia	Yes	No
Heart Defects	Yes	No

   If yes, what is the person's relationship to you or the baby's father? ____________________

3. Do you, the baby's father or a close relative in either of your families have a birth defect, any familial disorder or a chromosomal abnormality (not listed above) that you are aware of?

   If yes, what is the condition and who has it? ____

4. Are you or the baby's father of Jewish or French Canadian ancestry? Yes No
   If yes, have either of you been screened for Tay Sach's Yes No

   If yes, indicate the results for either you or the baby's father. ____________________________

5. Have you or the baby's father been screened for Sickle Cell Trait? Yes No

   If yes, indicate the results for either you or the baby's father _____________________________

6. Excluding vitamins, have you taken any medications or used any drugs since being pregnant or since your last menstrual period? Yes No

   If yes, what medications or drugs?____

7. Do you wish to be tested for the Cystic Fibrosis gene? Yes No