



235 Plain Street
 Providence, RI
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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 (ie. Spinal 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?

	YES	NO
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*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
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*If yes, have either of you been screened for Tay Sach's _____

*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
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*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
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*If yes, what medications or drugs: _____
7. Do you wish to be tested for the Cystic Fibrosis Gene?

	YES	NO
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FOR PHYSICIAN USE:

1 st Trim. Screen (NT and 1 serum)	Offered	Accepted	Declined
Serum Interg. (2 serums)	Offered	Accepted	Declined
Full Integrated (NT and 2 serums)	Offered	Accepted	Declined
AFP QUAD	Offered	Accepted	Declined
Amnio	Offered	Accepted	Declined
CVS	Offered	Accepted	Declined
Level II	Offered	Accepted	Declined
Genetic Counseling	Offered	Accepted	Declined
Tay Sachs	Offered	Accepted	Declined
Cystic Fibrosis	Offered	Accepted	Declined
Sickell Cell	Offered	Accepted	Declined
Early Glucose Scrn.	Offered	Accepted	Declined
Hgb Electrophor	Offered	Accepted	Declined