BRICK WOMEN'S PHYSICIANS
GENETIC TESTING ACKNOWLEDGEMENT FORM

NAME_____
DATE OF BIRTH_____
TODAY'S DATE_____
FIRST DAY OF LAST MENSTRUAL PERIOD_____

	Please circle	
1. Will you be age 35 or older when the baby is due?	**YES**	**NO**
2. Have you or the baby's father had a previous child or brother or sister with Down's Syndrome or other genetic abnormalities?	**YES**	**NO**
3. Were you, the baby's father, any other children, or any close relative born with a neural tube defect (spina bifida, anencephaly)?	**YES**	**NO**
4. Does any relative in your family have Hemophilia, Muscular Dystrophy or Hydrocephalus (water on the brain)?	**YES**	**NO**
5. Do you or the baby's father have a birth defect, or have you had a child born dead or alive with a birth defect not listed above?	**YES**	**NO**
6. Does any relative on either side of the family have Cystic Fibrosis?	**YES**	**NO**
7. Are there any other known inherited or chromosomal disorders, or Structural deformities in either family?	**YES**	**NO**
8. Do you have one or more close relatives who are mentally retarded?	**YES**	**NO**
9. Are you and the baby's father closely related (for example -- cousins)?	**YES**	**NO**
10. Certain Genetic Diseases are more common in certain ethnic groups:		
A. Are you or the baby's father African American?	**YES**	**NO**
If yes have you/he been tested for sickle cell trait?	**YES**	**NO**
B. Are you or the baby's father Jewish?	**YES**	**NO**
If yes, have you/he been tested for Tay-Sachs Disease?	**YES**	**NO**
C. Are you of Asian or Mediterranean (Greek , Italian) descent?	**YES**	**NO**
If yes have you been tested for Thalassemia trait?	**YES**	**NO**
11. Have you taken any medicines or drugs (prescription or not) during this pregnancy?	**YES**	**NO**
If yes please list here_____		
12. Did you smoke, drink alcohol, or take any drugs during this pregnancy?	**YES**	**NO**
13. Have you had any miscarriages or stillbirths?	**YES**	**NO**
14. In any previous pregnancies, have you or the baby's father had a stillborn child or three or more first trimester pregnancy losses?	**YES**	**NO**
15. Did you have <u>any</u> problems in previous pregnancies?	**YES**	**NO**

Please explain what problems_____

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Please ***circle*** yes or no to **all** of the following questions:

*******PLEASE SELECT ONE METHOD ONLY*******

1. Quad Screen:

It is recommended that pregnant women be offered a screening test for certain birth defects such as Down's syndrome, neural tube or spinal cord defects and others. This test is called the Quad Screen. It is a blood test that analyzes four different hormone levels and must be done in the second trimester. The test also takes into account your age , weight, race and whether or not you have diabetes or are carrying twins.

Because it is a screening test---it is not used to *diagnose* birth defects. It only identifies those women who may be at higher risk of having a baby with birth defects. **It is not a perfect test---a negative result cannot guarantee that your child will have no defects at birth. Likewise, a positive test does not mean that your child will definitely have birth defects.** If it comes back positive, you may be offered additional testing which may include genetic counseling, ultrasound, or amniocentesis.

This test is not mandatory; it is your decision whether or not to have the Quad screen done. Please ask your doctors if you have any questions.

YES I want the quad screen done

☐ **NO** I do not want the quad screen done

_____ _____

Patient signature Date

2. Nuchal Translucency

The Nuchal Translucency test is done by a Perinatologist (High Risk Doctor) and consists of a blood test and ultrasound done of the baby's nuchal (neck) fold in the first trimester. This testing can be used as a screening test to see if your baby may be at risk for Down's Syndrome. **Please be aware that this is not a perfect test---a negative result cannot guarantee that your child will have no defects at birth. Likewise , a positive test does not mean that your child will definitely have birth defects.** You will need to get another blood test and an ultrasound in the second trimester. You are responsible for scheduling and obtaining this test with a perinatologist. Please ask your doctors if you have any questions.

☐ **YES** I want the nuchal translucency done

☐ **NO** I do not want the nuchal translucency done

_____ _____

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3. Amniocentesis or CVS (chorionic villi sampling):

The amniocentesis (usually done in the second trimester) involves placing a needle in the amniotic fluid of your baby and removing some fluid. The fluid is tested for some genetic abnormalities like Down's Syndrome. A CVS (usually done in the first trimester) consists of placing a needle into the placental tissue of your baby and testing that tissue for some genetic abnormalities like Down's Syndrome. There is a risk of losing the pregnancy with these tests. Generally , we don't recommend this testing option unless you are over age 35. Please ask your doctors if you have any questions.

☐ **Yes** I want the amniocentesis done

☐ **Yes** I want the cvs done

☐ **NO** I decline to have the amniocentesis or cvs done

_____ _____

Patient signature Date

IN ADDITION TO THE ABOVE TESTING, Other options include but are not limited to:

Cord blood banking:

Cord Blood banking is available for those parents who wish to have this procedure done at delivery. The preserved cord blood may be used by family members to treat some diseases. Arrangements must be made in advance of the delivery by the parents of the baby to have this procedure done. It is not covered by insurance. Please ask your doctors if you have any questions.

☐ **Yes** I want to have the cord blood banked

☐ **NO** I do not want to have the cord blood banked

_____ _____

Patient signature Date:

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HARMONY TEST:
The Harmony test assesses the risk for chromosome conditions such as Downs syndrome and includes an optional analysis of fetal sex and sex chromosome (X,Y) conditions. It is obtained from your blood after 10 weeks. **Please be aware that this is not a perfect test---a negative result cannot guarantee that your child will have no defects at birth. Likewise , a positive test does not mean that your child will definitely have birth defects.** Also note that fetal sex determination is greater than 99% accurate with this test. Please ask your doctors if you have any questions. It may not be covered by insurance.

Yes I want the Harmony Test with Fetal sex determination

Yes I want the Harmony Test without Fetal sex determination

No: I do not want the Harmony Test

Do nothing:

For personal reasons some patients decline all genetic testing.

☐ I decline genetic testing. I do not want a Quad screen, amniocentesis , CVS, genetic counseling, Cord Blood Banking, Nuchal Translucency or Harmony testing.

_____ _____
Patient signature Date

Please note:
All pregnant women are advised to obtain a flu shot at any time during their pregnancy. All pregnant women are also advised to obtain a tDap (whooping cough) vaccine in the third trimester to help protect you and your newborn baby. These can be obtained at your primary care office or at a local pharmacy (Walgreens in Brick).

PLEASE SIGN BELOW:

Testing Acknowledgement Form Acknowledgement

I have read and received the genetic testing acknowledgement form and I am also aware that I need to obtain a flu shot and tDap vaccine during this pregnancy.

_____ _____
Patient signature Date