

# NEW OB ONLY

## Prenatal Genetic Screen

Name \_\_\_\_\_

Date \_\_\_\_\_

1. Will you be 35 years or older when the baby is born? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have you, the baby's father, or anyone in either of your families ever had any of the following?
- Down Syndrome (mongolism) Yes \_\_\_\_\_ No \_\_\_\_\_
  - Other Chromosomal abnormality Yes \_\_\_\_\_ No \_\_\_\_\_
  - Neural tube defect, i.e. spina bifida (meningomyelocele or open spine), anencephaly Yes \_\_\_\_\_ No \_\_\_\_\_
  - Hemophilia Yes \_\_\_\_\_ No \_\_\_\_\_
  - Muscular Dystrophy Yes \_\_\_\_\_ No \_\_\_\_\_
  - Cystic fibrosis Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate the relationship of the affected person to you or the baby's father:

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3. Do you or the baby's father have a birth defect? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who has the defect and what is it? \_\_\_\_\_

4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who had the defect and what was it? \_\_\_\_\_

5. Do you or the baby's father have any close relatives with mental retardation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate the relationship to you or the baby's father and the cause, if known:

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6. 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?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate the condition and relationship of the affected person to you or to the baby's father:

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7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes \_\_\_\_\_ No \_\_\_\_\_

8. Have either of you had a chromosomal study? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

9. If you or your baby's father are African-American, have either of you been screened for sickle cell trait? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

10. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

11. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for thalassemia? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

12. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for alpha-thalassemia? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

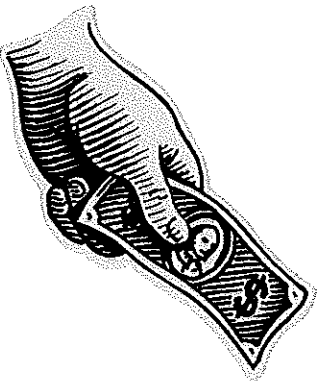
13. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs)

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give name of medication and time taken during pregnancy: \_\_\_\_\_

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## Obstetrics Financial Policy



Financial Planning

### Insurance

CWH will contact your insurance company as soon as we become aware of your pregnancy and estimated delivery date. We will verify your eligibility, inquire and confirm what amounts will be paid by the insurance company and what amounts, if any, will be your responsibility. For example, many plans will have a deductible amount and/or co-insurance amount that are the patient's responsibility.

### Patient Balances Due

All balances that are "patient responsibility" such as co-pays, deductibles and non-covered services must be paid in full by week 28 of your pregnancy. CWH will work out a payment plan for balances that pose financial burdens, however we are not able to extend the plan beyond week 28. We participate with CARE CREDIT patient financing and will place an application for financing with CARE CREDIT if you need additional time for payment.

### Ancillary Services

During your pregnancy you may have various laboratory testing, ultrasounds or genetic counseling sessions ordered by one of our clinicians. These outside services may be performed at CWH, however, we are not the billing provider. These services are not payable to CWH and can we cannot provide information regarding charges for these services.

### Medical Assistance

CWH is not a participating provider with any public medical assistance plans. If you are currently enrolled in medical assistance or plan to be enrolled in medical assistance during your pregnancy, we will not be able to provide obstetrical services for your pregnancy and will transfer you to a provider of your choice that is participating with medical assistance programs.



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