



### GENETIC DATA

Patient's Name: \_\_\_\_\_ Attending Physician: \_\_\_\_\_

<u>Screening Questionnaire</u>	Yes	No
1. Will you be age 35 or older when you have children?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or your partner, or anyone in either of your families, ever had Cystic Fibrosis? Have you ever received genetic screening for cystic fibrosis? Upon your physician's recommendation, do you consent to genetic screening for Cystic Fibrosis?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Have you or your partner or anyone in either of your families ever had: a. Down's Syndrome (mongolism)? b. Spina Bifida or Meningomyelocele (open spine)? c. Hemophilia? d. Muscular Dystrophy?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. Have you or your partner had a child born dead or alive with a birth defect not listed in question 2 or 3 above? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you or your partner have any close relatives who are mentally retarded or have birth defects? If yes, list cause, if known: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you or your partner or a close relative in either family have any inherited genetic or chromosomal disease or disorder not listed above? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you or your partner had three or more spontaneous pregnancy losses, miscarriages, stillbirths, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)? If yes, have either you or your partner been screened for Tay-Sachs disease? If yes, indicate results and who was screened: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
9. Are you or your partner black? If yes, have either you or your partner, or any close relative ever been screened for sickle cell trait and found to be positive? If yes, indicate results and who was screened: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
10. Do you or your partner have any close relatives descended from Mediterranean countries? If yes, have you or your partner been screened for thalassaemia (Cooley's anemia)? If yes, indicate results and who was screened: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
11. Do you drink alcoholic beverages? If yes, describe how often and amount: _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you take any medications either by prescription or those which can be purchased over the counter in a drugstore? If yes, please list drugs and dosage schedule: _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been tested to determine if you are immune to Rubella (German Measles)? If yes, please indicate where and when tested and results of test: _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WRITTEN CONSENT FOR PERINATAL HIV ANTIBODY TESTING**

PATIENT'S NAME: \_\_\_\_\_

ORDER GIVEN: \_\_\_ YES \_\_\_ NO

The Illinois HIV Prevention Act mandates that all women in the state of Illinois must be counseled and offered an HIV test during pregnancy, with the test result or a notation of test refusal documented in the prenatal record, the labor and delivery record and the newborn pediatric record. The HIV test is a test to determine the presence of the antibody to HIV, the agent that causes AIDS. If you refuse to allow your physician to test you for HIV during your pregnancy, or you are tested by your physician but you arrive at a hospital for delivery with no documented HIV status, the law requires that the hospital offer you "rapid HIV testing" (an HIV test that provides results in one hour) so that antiretroviral therapy can be administered and significantly reduce the risk of HIV transmission to your child. This rapid HIV test is not currently available at all Illinois hospitals, but is planned to be made available through a program conducted by the Illinois Department of Public Health by the summer or fall of 2004. Additionally, if the hospital is unable to verify that you have been tested for HIV and obtain the results of the test from your physician at the time of delivery, the hospital will be required to test your newborn for HIV, unless you refuse in writing to allow the testing. The purpose of this form, therefore, is to obtain your consent to be tested for HIV, and your consent to release your identity and the results of the test to any hospital at which you present for delivery or other healthcare treatment.

I am giving my permission for a blood test in order to detect whether I have antibodies to the HIV virus (Human Immunodeficiency Virus) or any other identified causative agent of AIDS in my blood. I understand the test results will be utilized for the purposes of my medical care and treatment.

I understand that the test is performed by withdrawing a sample of my blood and conducting laboratory tests to determine the presence of antibodies to HIV. I understand that the results of the blood tests considered to be positive will be reported to the Illinois Department of Public Health.

I further understand that a positive result does not mean I have AIDS, but that my blood has been exposed to the AIDS virus, and antibodies to that virus are present in my blood. I understand that counseling concerning AIDS will be offered to me if my test results are found to be positive.

I have been informed and understand that the test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result), or that the test may fail to detect that a person has antibodies to the virus when the person does, in fact, have these antibodies (a false negative result).

I understand that my test results will be released to my physicians and other healthcare providers providing my care. This includes any hospital at which I present for delivery or other healthcare treatment. In addition, I understand that the law allows my identity and test results to be disclosed to specific persons, such as the physicians and healthcare providers involved in the use of any donated organs or tissue, and the Illinois Department of Public Health, healthcare facility staff committees, and research studies (without name). I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time, prior to the completion of the laboratory tests.

My physician has advised me about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw at any time prior to the completion of laboratory tests; and the confidentiality protection under the law. I understand that the fact that the test was performed and the results may be released to my insurance carrier.

With the information presented above having been completely and clearly explained to me and all of the questions having been answered, I agree to have my blood tested for HIV infection.

I refuse HIV testing at this time. I understand I can request this test at a later date if I change my mind.

\_\_\_\_\_  
Signature of Patient or Legally  
Authorized Representative

\_\_\_\_\_  
Signature of Physician/Nurse

\_\_\_\_\_  
Date



## LETTER OF AGREEMENT

We are pleased that you have chosen DuPage Health Specialists for your obstetrical care. The services normally provided in uncomplicated maternity cases include care prior to delivery (antepartum), during delivery, and after delivery (postpartum).

Antepartum care includes: the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits within this period will be billed separately.

Postpartum care includes: standard visits while in the hospital and an office visit usually conducted at six weeks.

The above services are included in the standard vaginal delivery or cesarean-section package. Our fee for vaginal delivery package \$3,832 and for a cesarean section package is \$5,119.

Additional services that may be required during your pregnancy and delivery but that are not included in the obstetrical package include but are not limited to:

Pap Smear	Venipuncture	Amniocentesis
GC/Chlamydia test	CBC w/platelets	Circumcision
Urine Culture	Hepatitis B Surface Antigen	Non-Stress Test
U/A without Micro	RPR/VDRL	Hospital Ultrasounds
Rubella Screening	Type & Screen	Office Ultrasounds
AFP/AFP Plus	Glucola, 50 gram	

Except for the AFP/AFP Plus, all blood work will be ordered by your physician and you will be directed to use Quest Laboratories, Edward Hospital's lab, or Hinsdale Hospital's lab.

In addition to your physician's bill, you may receive bill(s) from the hospital, anesthesiologist, radiologist, neonatologist, or laboratory – depending on what additional services are utilized.

We would like to ensure that you receive the maximum legitimate benefits from your insurance plan. As a courtesy to you, we will contact your insurance company to obtain an estimate on your coverage. You will be responsible for copayments and deductibles. **If you don't have 100% insurance coverage or have a large deductible, we will work out a payment plan with you that must be completed prior to your expected delivery date.** Please alert us to any possible changes in job or insurance status. **Most insurance plans require payment of designated copay at the FIRST OB VISIT ONLY and not at subsequent return ob visits.** Copays will be collected for any non-routine, problem visits occurring during the pregnancy. **To facilitate coverage for your newborn, you must notify your insurance company immediately upon delivery.**

We look forward to assisting you in any way possible.

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I understand the above explanation of obstetrical charges and that all costs incurred are ultimately my responsibility regardless of insurance coverage. I also understand that Drs. Hsia, Bromberger, and Dunn are on staff at both Edward Hospital and Hinsdale Hospital.

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Patient Signature

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Date

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Patient Name (printed)