

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y): _____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ County (CA only): _____ Occupation: _____

PARTNER INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y): _____ Age: _____

Occupation: _____ Is your partner the biological father of the pregnancy? NO YES

If no, did you use a sperm donor? NO YES

PATIENT CONTACT INFORMATION AND AUTHORIZATION

Cell: _____ Home: _____ Work: _____

May we leave a detailed voice message that includes **confidential medical information and test results**? YES NO

If YES, check all that apply: Cell Home Work

If we are unable to reach you, is there another person with whom we can leave a detailed voice message that includes **confidential medical information and test results**: NO YES If YES, complete below:

Name: _____ Relationship: _____ Number: _____

•Patient has the right to revoke permission for the confidential voice mail •Patient assumes responsibility for information left on the confidential voice mail

REFERRING DOCTOR (PRIMARY OB/GYN) OR CLINIC INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

PREGNANCY AND EXPOSURE INFORMATION

Do you have or have you ever had any of the following?

Diabetes? NO YES
 Seizure disorder? NO YES
 Lupus? NO YES
 Graves' disease or Hashimoto
 Thyroiditis or thyroid cancer? NO YES

Do you take any medications on a regular basis? NO YES

If yes, please specify. If you are pregnant, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol): _____

Are you currently pregnant? NO YES

Due date: _____

Since becoming pregnant, have you had any:

Cigarettes NO YES _____
 Alcohol NO YES _____
 Recreational Drugs NO YES _____
 Fevers (greater than 101° F) NO YES _____
 X-rays (other than dental) NO YES _____

Are you or the biological father of the pregnancy adopted?

NO YES If yes, please specify: _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: _____ **DATE:** _____



Genetic Counseling Patient Rights and Obligations

Reproductive Genetic Counseling

Your health care provider has referred you to Integrated Genetics/Esoterix Genetic Laboratories for genetic counseling. In addition to providing genetic counseling services, Integrated Genetics/Esoterix Genetic Laboratories performs genetic testing. Genetic counselors support patients and their physicians by identifying genetic risks, explaining appropriate genetic testing options, discussing the implications of test results, and helping patients make informed healthcare decisions.

During the genetic counseling session, the genetic counselor will ask you detailed questions about your personal reproductive history, as well as your personal and family medical history. Based on the information provided during the session, the genetic counselor will identify and discuss identified genetic risk factors that may affect you or your offspring. The genetic counselor will explain any available test and procedure options, such as amniocentesis, including their benefits and limitations. Based on your inclination and your judgment, you decide whether or not to have any genetic tests or procedures. The decision is entirely yours.

It is important to understand that the genetic counselor will use only the information provided by you and your health care provider's office in order to assess specific genetic risks. It is your responsibility to ensure that the information provided to the genetic counselor is as accurate and complete as possible. If any relevant genetic test results are unavailable at the time of genetic counseling, the genetic counselor cannot provide you with the most relevant risk assessment regarding these test results and the underlying genetic condition(s). It is your responsibility to contact your current and former health care provider's offices to forward any relevant test results to the genetic counselor and to contact the genetic counselor to schedule a follow-up consultation if you desire further risk assessment regarding these test results. If you learn any new or different information about your family or reproductive history, it is likewise your responsibility to recontact the genetic counselor following your genetic counseling appointment. If you choose to email necessary test results or other medical information or records to your genetic counselor, you will assume all responsibility for the security of the e-mail transmission and any potential risk of your e-mail being misdirected to any unintended recipient.

Our policy prohibits audio/video recording of the genetic counseling session or taking photographs/video of the materials or genetic counselor.

You may decide to proceed with the genetic testing that you discussed with the Integrated Genetics' genetic counselor. It is your responsibility to ensure the testing you have requested is performed. Your physician is responsible for ordering the testing and selecting the laboratory which will perform the testing.

Your genetic counselor will discuss with you how you will receive your test results. Results for most genetic tests are available in approximately 2 to 3 weeks. If you are expecting that either the genetic counselor or your health care provider's office will contact you with test results, and you have not heard from them in 2 to 3 weeks after testing, you should contact either your health care provider's office or the genetic counselor.

The genetic counselor provides genetic counseling at the request of your health care provider. Charges for genetic counseling and any genetic testing are separate from any ultrasound or physician charges during your pregnancy. Integrated Genetics/Esoterix Genetic Laboratories will bill your insurance company if you have provided insurance information to us. You will be responsible for payment of any remaining balance, including any deductible, co-payment or co-insurance.

Thank you for reviewing this and we hope you find this information helpful in understanding the role of genetic counseling. Please sign below to acknowledge that you have received and reviewed the above information.

Patient Name: _____	Date of Birth: _____
Patient Signature: _____	Date: _____
Genetic Counselor: _____	Phone: _____ Date: _____

Integrated Genetics Genetic Counseling ♦ Phone 855-GC CALLS (855-422-2557)

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