Minal Mehta, M.D. A Professional Corporation
Diplomate, American College of Obstetrics and Gynecology
18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708
Phone: (714) 848-2383
Facsimile: (714) 848-4083

PATIENT INFORMATION FORM

This information is confidential. We appreciate your cooperation in filling out this form as completely as possible.

Please Print Clearly

Your Full Name: _____ Date: _____

Home Address: _____ City/State/Zip: _____

Phone: Home: _____ Work: _____ ext: _____

Mobile: _____ E-Mail: _____

Birthdate: _____ Age: _____

Married: _____ Single: _____ Widowed: _____ Divorced: _____ Separated: _____

Social Security #: _____ Drivers License #: _____

Who referred you to us?: _____

Your Employer: _____ Occupation: _____

Your Work Address: _____ City/State/Zip: _____

Insurance Company: _____ ID#: _____ Group#:_____

Race/Ethnicity: _____ Language: _____

Spouse/Insured's information:

Name: _____ Relationship: _____

Home Address: _____ City/State/Zip: _____

Birthdate: _____ Age: _____

Social Security #: _____ Occupation: _____

Employer: _____ Phone: _____

Work Address: _____ City/State/Zip: _____

Medical Insurance: _____ ID #: _____ Group #: _____

Person to contact in case of emergency: _____ Phone: _____

Relationship to the patient: _____

I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Dr. Minal Mehta. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges to services rendered me whether or not paid by said insurance or in the event I am not eligible for insurance. I hereby authorize and assign to release all information necessary to secure payment.

_____ _____

Signature Date

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PATIENT HISTORY

Name: _____ Date: _____
LAST FIRST MIDDLE

ID#: _____ Hospital of Delivery: _____

Newborn's Physician: _____ Referred By: _____

Final EDD Primary: _____ Provider/Group: _____

BIRTH DATE / AGE / RACE / MARITAL STATUS (S M W D SEP)	ADDRESS
MONTH DAY YEAR	ZIP PHONE (H) (o)
LANGUAGE	INSURANCE CARRIER/MEDICAD#
HUSBAND/DOMESTIC PARTNER PHONE	POLICY#
FATHER OF BABY PHONE	EMERGENCY CONTACT

TOTAL PREG	FULL TERM	PREMATURE	AB, INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

☐ DEFINITE ☐ APPROXMIATE (MONTH KNOWN) ☐ MENES MONTHLY ☐ YES ☐ NO FREQUENCY: 0_____ DAYS MENARCH: _____ (AGE ONSET)

☐ UNKNOWN ☐ NORMAL AMOUT/DURATION PRIOR MENES _____ DATE ON PCP AT CONCEPT ☐ YES ☐ NO ICG : _____ / _____ / _____

☐ FINAL _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE * TREATMENT			O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE * TREATMENT
1. DIABETES				17. D (Rb) SENSITIZED		
2. HYPERTENSION				18. PULMONARY (TB. ASTHMA)		
3. HEART DISEASE				19. SEASONAL ALLERTIES		
4. AUTOIMMUNE DISORDER				20. DRUG/LATEX ALLERTIES/ REACTIONS		
5. KIDNEY DISEASE/UTI						
6. NEUROLOGIC/EPILEPSY				21. BREAST		
7. PSYCHIATRIC				22. GYN SURGERY		
8. DEPRESSION/POSTPARTUM DEPRESSION						
9. DIABETES				23. OPERATIONS HOSPITALIZATIONS (YEAR & REASON)		
10. HEPATITUS/LIVER DISEASE						
11. VARICOSITIES/PHLEBITIS						
12. THYROID DYSFUNCTION				24. ANESTETIC COMPLICATIONS		
13. TRAMA/VIOLENCE				25. HISTORY OF ABNORMAL PAP		
	AMT/DAY PREPREG	AMT/DAY PREG	#YEARS USE	26. UTERINE ANOMALY/DES		
14. TOBACCO				27. INFERTILITY		
15. ALCOHOL				28 RELEVANT FAMILY HISTORY		
16. ILLICIT/RECREATIONAL DRUGS				29. OTHER		

Comments: _____

_____

ACOG ANTEPARTUM RECORD (FORM A)

SYMPTOMSSINCELMP

	YES	NO		YES	NO
1.PATIENT'SAGE(35OROLDER)			12.MENTALRETARDATION/AUTISM		
2.THALASSEMIA(ITALIAN,GREEK,MEDITERRANEAN,ORASIAN BACKGROUND)MCV<80			IFYES,WASPERSONTREATEDFORFRAGILEX?		
3.NEURALTUBEDEFECT (MENINGOMYELOCELE,SPINABIFIDA,ORANENCEPHALY)			13.OTHERINHERITEDGENETICORCHROMOSOMALDISORDER		
4.CONGENITALHEARTDEFECT			14.MATERNALMETABOLICDISORDER(EG.INSULINDEPENDENT DIABETES,PKU)		
5.DOWNSYNDROME			15.PATIENTORBABY'SFATHERHADACHILDWITHBIRTHDEFECTS NOTLISTEDABOVE		
6.TAY-SACHS(EG.JEWISH,CAJUN,FRENCH-CANADIAN			16.RECURRENTPREGNANCYLOSS,ORASTILLBIRTH		
7.SICKLECELLDISEASEORTRAIT(AFRICAN)			17.MEDICATIONS/STREETDRUGS/ALCOHOLSINCELASTMENSTRUAL PERIOD		
8.HEMOPHILIA			IFYES,AGENT(S)		
9.MUSCULARDYSTROPHY			18.ANYOTHER		
10.CYSTICFIBROSIS					
11.HUNTINGTONCHOREA					

COMMENTS/COUNSELING _____

INFECTIONHISTORY	YES	NO		YES	NO
1.HIGHRISKHEPATITISB/IMMUNIZED?			4.RASHORVIRALILLNESSSINCELASTMENSTRUALPERIOD		
2.LIVEWITHSOMEONEWITHTBOREXPOSEDTOTB			5.HISTORYOFSTD.GC.CHLAMYDIAHPV.SYPHILIS		
3.PATIENTORPARTNERHASHISTORYOFGENITALHERPES			6.OTHER(SEECOMMENTS		

COMMENTS _____

INTERVIEWER'SSIGNATURE _____

INITIALPHYSICALEXAMINATION

DATE ____ / ____ / ____ PREPREGNANCYWEIGHT _____ HEIGHT _____ BP _____

1.HEENT	☐ NORMAL	☐ ABNORMAL	12.VULVA	☐ NORMAL	☐ ABNORMAL
2.FUNDI	☐ NORMAL	☐ ABNORMAL	13.VAGINA	☐ NORMAL	☐ ABNORMAL
3.TEETH	☐ NORMAL	☐ ABNORMAL	14.CERVIX	☐ NORMAL	☐ ABNORMAL
4.THYROID	☐ NORMAL	☐ ABNORMAL	15.UTERUSSIZE	☐ NORMAL	☐ ABNORMAL
5.BREASTS	☐ NORMAL	☐ ABNORMAL	16.ADNEXA	☐ NORMAL	☐ ABNORMAL
6.LUNGS	☐ NORMAL	☐ ABNORMAL	17.RECTUM	☐ NORMAL	☐ ABNORMAL
7.HEART	☐ NORMAL	☐ ABNORMAL	18.DIAGONALCONJUGATE	☐ NORMAL	☐ ABNORMAL
8.ABDOMEN	☐ NORMAL	☐ ABNORMAL	19.SPINES	☐ NORMAL	☐ ABNORMAL
9.EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20.SACRUM	☐ NORMAL	☐ ABNORMAL
10.SKIN	☐ NORMAL	☐ ABNORMAL	21.SUBPUBICARCH	☐ NORMAL	☐ ABNORMAL
11.LYMPHNODE	☐ NORMAL	☐ ABNORMAL	22.GYNECODPELVICTYPE	☐ NORMAL	☐ ABNORMAL

COMMENTS (Numberandexplainabnormals) _____

EXAMBY _____

31. HOSPITALIZATIONS List those operations/serious illnesses that have required hospitalization. If more than six, check this box. Do not include pregnancies here.

Month/Year	Illness or Operation	Complications Yes	Complications No
/			
/			
/			
/			
/			
/			

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ..... ☐
Type _____
Amt/Day _____

33. Tobacco ..... ☐
Type _____
Amt/Day _____

34. Caffeine ..... ☐
Type _____
Amt/Day _____

35. Non-Prescribed Drugs ..... ☐
Type _____
Amt/Day _____

36. Street Drugs ..... ☐
Type _____
Amt/Day _____

Signature: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Minal Mehta, M.D. A Professional Corporation may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Minal Mehta, M.D. A Professional Corporation's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doctors of OGBYN reserves the right to revise it's Notice of Privacy at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer of Minal Mehta, M.D. at 18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708.

With my consent, Minal Mehta, M.D. A Professional Corporation may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Minal Mehta, M.D. A Professional Corporation may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Minal Mehta, M.D. A Professional Corporation's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Minal Mehta, M.D. A Professional Corporation may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian

_____ _____
Office Staff Signature Date

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PAITENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Minal Mehta, M.D. A Professional Corporation to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below

This authorization permits Minal Mehta, M.D. A Professional Corporation to use or disclose to any laboratory, hospital, or other physicians or insurance company, the following individually identifiable health information (such as date(s) of service, level of detail to be released, origin of information, etc.): as it relates to my care at Minal Mehta, M.D. A Professional Corporation.

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protect3ed by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Minal Mehta, M.D. has acted in reliance upon this authorization. My written revocation must be submitted to Minal Mehta, M.D. A Professional Corporation's Privacy Officer at 18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708.

_____
Patient's Signature

_____ _____
Patient's Name (please print) Date

Minal Mehta, M.D. OBGYN *Phone (714) 848-2383*
18111 Brookhurst St. #4450 Fountain Valley, CA 92708 *Fax (714) 848-4083*

FINANCIAL POLICY

Thank you for choosing Dr. Mehta. We are committed to the success of your treatment. We hope you understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctor.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due at the time of services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are **NOT contracted** with or **DO NOT have insurance** will be required to pay as a "Out of Pocket Patient" for the initial consultation in full. For any follow up visits, patients will need to pay accordingly. There may be 30% or more down payment prior to any surgery needed.

For prescriptions, if you are in need of a refill, please have your pharmacy fax a request to **714-848-4083**. (Please allow 48 to 72 hrs.) No pain medication will be given to post operative patients after 90 days of surgery. Our physician **DOES NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

FEES AND PAYMENTS
Physicians share the concern of their patient regarding the increasing cost of medical care. Our fees are within the customary range for this area and reflect the high level of care you will receive. We have standardized charges for various procedures, but these can vary depending on unforeseen circumstances that might arise. If you have any questions about fees, we encourage you to discuss them with our business office. The fees for obstetrical care include all routine obstetrical care from your first visit through your prenantal care, your delivery and your post partum visit six weeks following delivery. If a cesarean birth is necessary there will be additional charges.

ALL MEDICAL BILLS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED FOR CASH PATIENTS
We accept payments by cash, personal checks, Mastercard and Visa. This will help control the expensive process of billing and collections. If your medical services are greater than anticipated, we will be happy to arrange a payment plan with you. If you are having financial difficulty, please contact our business office.

INSURANCE
Please remember that your insurance coverage is a contract between you and your insurance carrier. Please contact your insurance company to verify that your doctor is a provider with your insurance. If you wish to file an insurance claim, we will furnish you with an itemized statement of your services and diagnosis, if one is established, and you can forward this statement on to your insurance company. Payment for services rendered is expected at the time of each visit, regardless of your insurance coverage. In some cases, your insurance company will only cover a portion of our fees. Since our relationship is with you and not your insurance company, our bill is your responsibility. We would appreciate it if you would give it a prompt attention. We will be glad to help you if you have a problem with your claim.

PPO INSURANCE
If you are a member of a Preferred Provider Organization (PPO) and our office has signed a contract to provide services for your PPO, we will handle all the billing of your insurance. You MUST provide us with a copy of your insurance card at the time of service. You are REQUIRED to pay any co-payments at this time. If you require lab work it will be sent to an outside lab. Certain PPO's have contracts with specific labs. You will be given a referral slip and you may go to that lab for your test. If you do not ask for a referral, we will send your specimen to our usual lab and we WILL NOT be responsible for any outside lab fees that you may be charged. We realize this can be confusing and we will work with you in any way we can to maximize your insurance benefits.

HMO INSURANCE

If you are a member of a Health Maintenance Organization (HMO) and our physicians have signed a contract to provide services for your HMO, we will handle all the billing of your insurance services. Our doctors, in this practice, cannot be listed as you primary care physician. They are SPECIALISTS. You are required to pay any co-payments at the time of service. Please be aware that due to specific policies in HMO contracts, ALL LABS AND ULTRASOUNDS MUST be done outside our office to be covered.

Dr. Mehta has financial interests in certain facilities/companies she operates with. These include but are not limited to: CordTrack, Surgical Center of Irvine, and Memorial Care Surgical Center at Orange Coast.

There will be a fee of $100 for any surgery cancellation. These fees will offset the surgical preparations which are separate from the surgical facilities.

If you are insured with a plan, which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copay amount at time of each visit.

There is a fee of $25.00 or more for all disability, FMLA and any other forms/paperwork that you need to have filled out by the physicians. We may ask that you make an appointment to complete these forms.

There is a fee for any reports or medical records requested by attorneys, insurance companies, disability companies, etc… This charge will be determined by the information requested.

Our accepted methods of payment are VISA and MasterCard, cash and checks. There will be a $45 fee for any bounced checks, thereafter, patients are required to pay with “cash”. If requested a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patient’s responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating the doctors outside of the designated network or if the proper authorizations have not been obtained.

Again, thank you for trusting us with your gynecological and obstetrical care. If you have any questions regarding financial responsible or payment options, please contact our office.

_____ _____

Signature Date

Minal Mehta, M.D. OBGYN *Phone (714) 848-2383*
18111 Brookhurst St. #4450 Fountain Valley, CA 92708 *Fax (714) 848-4083*

Disability Form Policy

We require a one-time fee of $25.00 for all disability forms.

I have read the disability form policy and I understand that there is a fee for all disability forms.

_____
Date

_____
Signature

_____
D.O.B.

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CANCELLATION POLICY

We require a 24 hour cancellation notice for all appointments. There will be a $25.00 charge for missed appointments unless you have notified the office in advance.

I have read the cancellation policy and I understand that there will be a charge for all missed appointments.

_____
Date

_____
Your Signature

Minal Mehta, M.D. OBGYN *Phone (714) 848-2383*
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Cystic Fibrosis Testing Consent

Although there is no cure for CF this time, scientists are making progress in improving treatment and in searching for a cure. In the past many people with CF died at a very young age. Today, many are living into their 20's and 30's.

Is there a chance my baby could have Cystic Fibrosis?

- You can have a child with CF even if there is no history in your family (see chart below)

Approximate risk that a couple with *no family history* of CF will have a child with CF

Ethnic Background	Risks
Caucasian couple	1 in 3,000
Hispanic couple	1 in 8,000
African American couple	1 in 15,000
Asian American couple	1 in 32,000

- CF testing can help determine if you are a carrier and at risk to have a child with CF.
- If both carriers, there is a 1 in 4 (25%) chance, with each pregnancy, that they will have a child with CF.
- Carriers have one normal CF gene and one altered CF gene.
- People with CF have two altered CF genes.
- Most people have two normal copies of the CF gene.

What testing is available?

- There is a blood test that can be done to find out if you or your partner is a carrier.
- A National Institutes of Health (NIH) consensus statement developed by a panel of experts representing medical, legal, ethical and public perspectives recommends that CF carrier testing be offered to any couple planning a pregnancy and to any individual with a family history of CF.
- It is important to understand that CF carrier testing does not detect all CF carriers.
- If the test shows that you are both CF carriers, your unborn baby can be tested to find out if the baby has CF.

How much does it cost to have Cystic Fibrosis carrier testing?

- Cost and insurance coverage for CF carrier testing vary depending upon the laboratory used and your insurance policy.
- The average cost for CF carrier testing is $265 per person.

Your genetic counselor can provide you with more information about this testing and answer any of your questions. The counselor can also provide you with a detailed brochure about CF and your testing options.

_____ **NO**, I am not interested in CF carrier testing or in receiving more information about CF carrier testing.

_____ **YES**, I would like to have more information about CF carrier testing.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

Carrier Screening For Genetic Diseases

The goal of our practice is to make sure that you receive optimal care and attention to improve your chances of having a healthy pregnancy, and of course, a healthy child.

An important part of family planning is being informed about your testing options. One of these options is genetic carrier screening. Carrier screening can help you understand your risk of having a child with a genetic disease.

Typically carriers are healthy individuals; but when two parents are carriers of the same genetic disease they can have a child affected with the disease. Most people do not know they are carriers until they have a child born with the disease.

The Universal Genetic Test screens for diseases such as Cystic Fibrosis, Tay-Sachs disease, and Sickle Cell disease. Some genetic diseases can significantly impair a child's normal development. For some of these conditions, early treatment can improve pregnancy outcomes. Your doctor can provide you with the full list of tested diseases.

If both you and your partner are carriers for the same disease, your child has a 1 in 4 (25%) chance of having that disease. If you are found to have a high reproductive risk, you have options. You may decide to have preimplantation genetic diagnosis, a prepregnancy process that significantly reduces the risk that a child will inherit the genetic disease, or undergo testing during your pregnancy to make informed reproductive decisions. Some individuals consider adoption or opt to not have children. Even if you would not choose any of these options, you can use the information to prepare for the birth of a child with a genetic disorder. You will have the opportunity to speak with your physician or a genetic counselor about the medical options available to you.

Like any carrier screening test, some carriers will not be detected, so this test can reduce, but not eliminate, the chance for a genetic disease.

The Universal Genetic Test is covered by most insurance policies. The test results will be sent to your doctor in about two weeks and you will be notified shortly thereafter.

Please sign this form and feel free to ask your doctor if you have any further questions.

- ☐ My partner and I are both interested in the Universal Genetic Test.
- ☐ I am interested in the Universal Genetic Test.
- ☐ I am declining genetic carrier screening.

Signature	_____
Date	_____
Partner Signature [if applicable]	_____
Date	_____

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HIV Testing Consent

We recommend that all of our pregnant patients have A.I.D.S. testing.

H.I.V. (Human Immunodeficiency Virus) is the cause of A.I.D.S. The blood test checks for this virus. If you are at high risk for A.I.D.S., the test should be repeated at the end of pregnancy. The following factors would place you at higher risk:

- Intravenous drug use by you or any other sexual partner (current or past).
- If you have had multiple sex partners.
- If any of your sexual partners (current or past) have had multiple sexual partners.
- Prior blood product transfusion by you or any sexual partner (current or past).
- Sexual partner (current or past) who is bisexual.

If you think you are at higher risk for A.I.D.S., please inform your physician. If you have any questions, please ask us.

YES, I wish to undergo A.I.D.S. testing.

_____ _____

Signature Date

NO, I refuse to undergo A.I.D.S. I understand H.I.V. infection is a possible risk for me, my baby, and my sexual partners, but I do not want to be tested.

_____ _____

Signature Date

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Spinal Muscular Atrophy Testing Consent

SMA is a hereditary disease that is caused by dysfunctional motor neurons that are responsible for voluntary muscle movement, such as breathing, talking, swallowing, head and neck control, crawling and walking. Symptoms can start in infancy or in rare cases as an adult. Currently, there is no cure for SMA and the expected lifespan of someone affected by the most common form of SMA is less than a few years.

Is there a chance my baby could have Spinal Muscular Atrophy?

- You can have a child with SMA even if there is no history in your family. Carriers of this abnormal gene have no symptoms of SMA. (See chart below).

Approximate risk that a couple with *no family history* of SMA will have a child with SMA

Ethnic Background	Risks
Caucasian couple	1 in 47
Hispanic couple	1 in 68
African American couple	1 in 72
Asian American couple	1 in 59

- SMA testing can help determine if you are a carrier and at risk to have a child with SMA.
- If both carriers, there is a 1 in 4 (25%) chance, with each pregnancy, that they will have a child with SMA.

What testing is available?

- There is a blood test that can be done to find out if you or your partner is a carrier.
- It is important to understand that SMA carrier testing does not detect all SMA carriers.
- If the test shows that you are both SMA carriers, your unborn baby can be tested to find out if the baby has SMA.

How much does it cost to have Spinal Muscular Atrophy carrier testing?

- Cost and insurance coverage for SMA carrier testing vary depending upon the laboratory used and your insurance policy.

Your genetic counselor can provide you with more information about this testing and answer any of your questions.

_____ **NO**, I am not interested in SMA carrier testing or in receiving more information about SMA carrier testing.

_____ **YES**, I would like to have more information about SMA carrier testing.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

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Fragile X Testing Consent

Fragile X is a common source of genetic disability that can be inherited from any parent. Symptoms include intellectual and behavioral challenges such as delayed language and speech, learning disabilities, mental retardation, autism, hyperactivity and poor eye contact. There are also physical characteristics that can be seen more in adults of Fragile X such as long face and or large ears. Males tend to be affected more commonly and severely than females.

Is there a chance my baby could have Fragile X?

- You can have a child with Fragile X even if there is no history in your family. Carriers of this abnormal gene have no symptoms of Fragile X.
- Parents with family history of Fragile X and Fragile X related disorders or other history such as unexplained intellectual or developmental disabilities, autism, and infertility problems are at higher risk.
- Women more commonly are carriers of Fragile X than men.
  - Approximately 1 in 260 women and 1 in 800 males.
- Fragile X testing can help determine if you are a carrier and at risk to have a child with Fragile X.

What testing is available?

- There is a blood test that can be done to find out if you or your partner is a carrier.
- It is important to understand that Fragile X carrier testing does not detect all Fragile X carriers.
- If the test shows that you are both Fragile X carriers, your unborn baby can be tested to find out if the baby has Fragile X.

How much does it cost to have Fragile X carrier testing?

- Cost and insurance coverage for Fragile X carrier testing vary depending upon the laboratory used and your insurance policy.

Your genetic counselor can provide you with more information about this testing and answer any of your questions.

_____ **NO**, I am not interested in Fragile X carrier testing or in receiving more information about Fragile X carrier testing.

_____ **YES**, I would like to have more information about Fragile X carrier testing.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

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CORD BLOOD RELEASE FORM

Dear Patient,

Did you know what umbilical cord blood stem cells can be used to treat nearly 80 diseases, including several forms of cancers and blood related diseases, immunity and metabolic disorders and disease, such as leukemia and lymphomas?

Future applications such as regenerative medicine are also in an emerging area of medicine that will help treat many diseases that have previously been thought to be untreatable. Currently, there are over 3,000 clinical trials worldwide that involve researching the application of stem cells to treat injuries and disease, and that number will continue to grow.

As of February 2007, California state law requires care providers to inform expecting parents of their options regarding preserving umbilical cord stem cells.

The options for umbilical cord blood stem cells include the following:

- Discarding the stem cells as medical waste
- Donating the stem cells to a public bank for public use or for research
- Preserving the stem cells with a family cord blood bank for exclusive use for your child or immediate family

I acknowledge that I have been informed about the options concerning my newborn's umbilical cord blood.

Should I wish to obtain additional information about umbilical cord blood stem cell preservation, I fully understand that this responsibility will be solely and completely my own.

Patient Name	Patient Signature	Date

I provide my consent to be contracted by a local cord blood educator to learn more about my options:

Name: _____ Phone: _____

OBGYN: _____ Email: _____

Delivery Date: _____

Disease List

The following diseases are covered on Counsyl's Universal Genetic Test, listed here with the number of mutations tested.

ACOG = Testing for this disease recommended to be offered by ACOG

ACMG = Testing for this disease recommended to be offered by ACMG

*Disease must be specifically requested to be included in your panel.

Caucasian

ACOG ACMG Cystic Fibrosis (100)

ACMG Spinal Muscular Atrophy (1)

Medium Chain Acyl-CoA Dehydrogenase Deficiency (7)

Phenylalanine Hydroxylase Deficiency (11)

Ashkenazi Jewish

ACOG ACMG Tay-Sachs Disease (6)

ACOG ACMG Canavan Disease (4)

ACOG ACMG Cystic Fibrosis (100)

ACOG ACMG Familial Dysautonomia (2)

ACMG Bloom Syndrome (1)

ACMG Gaucher Disease (10)

ACMG Fanconi Anemia Type C (3)

ACMG Mucolipidosis IV (2)

ACMG Niemann Pick Disease, SMPD1-Associated (4)

ACMG Spinal Muscular Atrophy (1)

Glycogen Storage Disease Type 1a (7)

Joubert Syndrome 2 (1)

NEB-Related Nemaline Myopathy (1)

ABCC8-Related Hyperinsulinism (3)

Lipoamide Dehydrogenase Deficiency (2)

Maple Syrup Urine Disease Type 1B (3)

Usher Syndrome Types 1F and 3 (2)

Hexosaminidase A Deficiency (8)

African

ACOG ACMG Cystic Fibrosis (100)

ACOG Sickle Cell Disease (28)

ACMG Spinal Muscular Atrophy (1)

Middle Eastern

ACOG ACMG Cystic Fibrosis (100)

ACMG Spinal Muscular Atrophy (1)

Beta Thalassemia (26)

Familial Mediterranean Fever (5)

Phenylalanine Hydroxylase Deficiency (11)

Asian

ACOG ACMG Cystic Fibrosis (100)

ACOG Beta Thalassemia (26)

ACMG Spinal Muscular Atrophy (1)

* Glucose-6-Phosphate Dehydrogenase Deficiency (5)

Phenylalanine Hydroxylase Deficiency (11)

Wilson Disease (2)

Hispanic

ACOG ACMG Cystic Fibrosis (100)

ACMG Spinal Muscular Atrophy (1)

Sickle Cell Disease (28)

Phenylalanine Hydroxylase Deficiency (11)

Opt-In Diseases

* Factor V Leiden Thrombophilia (1)

* Glucose-6-Phosphate Dehydrogenase Deficiency (7)

* HFE-Associated Hereditary Hemochromatosis (2)

* MTHFR Deficiency (2)

* Prothrombin Thrombophilia (1)

Additional Diseases

Achromatopsia (3)

Alkaptonuria (11)

Alpha-1 Antitrypsin Deficiency (2)

Alpha-Mannosidosis (1)

Andermann Syndrome (2)

ARSACS (2)

Aspartylglycosaminuria (1)

Ataxia With Vitamin E Deficiency (1)

Ataxia-Telangiectasia (8)

Autosomal Recessive Polycystic Kidney Disease (4)

Bardet-Biedl Syndrome, BBS1-Related (1)

Bardet-Biedl Syndrome, BBS10-Related (1)

Biotinidase Deficiency (4)

Carnitine Palmitoyltransferase IA Deficiency (1)

Carnitine Palmitoyltransferase II Deficiency (3)

Cartilage-Hair Hypoplasia (1)

Choroideremia (1)

Cohen Syndrome (1)

Citrullinemia Type 1 (2)

CLN3- and CLN5-Related Neuronal Ceroid Lipofuscinosis (2)

Congenital Disorder Of Glycosylation Types 1a and 1b (5)

Congenital Finnish Nephrosis (2)

Costeff Optic Atrophy Syndrome (1)

Cystinosis (4)

D-Bifunctional Protein Deficiency (2)

Factor XI Deficiency (4)

Galactosemia (10)

GJB2-Related DFNB 1 Non-syndromic Hearing Loss and Deafness (7)

Glutaric Acidemia Type 1 (1)

Glycogen Storage Disease Types Ib, III, V (9)

GRACILE Syndrome (1)

Hereditary Fructose Intolerance (3)

Hereditary Thymine-Uraciluria (1)

Herlitz Junctional Epidermolysis Bullosa, LAMA3-, LAMB3-, and LAMC2-Related (5)

Hexosaminidase A Deficiency (8)

Homocystinuria Caused By Cystathionine Beta-Synthase Deficiency (1)

Hurler Syndrome (2)

Hypophosphatasia, Autosomal Recessive (4)

Inclusion Body Myopathy 2 (2)

Isovaleric Acidemia (1)

Krabbe Disease (2)

Limb-Girdle Muscular Dystrophy Type 2D and 2E (2)

Long Chain 3-Hydroxyacyl-CoA Dehydrogenase Deficiency (1)

Medium Chain Acyl-CoA Dehydrogenase Deficiency (2)

Megalencephalic Leukoencephalopathy with Subcortical Cysts (4)

Metachromatic Leukodystrophy (5)

Muscle-Eye-Brain Disease (1)

Neuronal Ceroid Lipofuscinosis CLN5-, CLN8-, PPT1- and TPP1-related (10)

Niemann-Pick Disease Type C (1)

Nijmegen Breakage Syndrome (1)

Northern Epilepsy (1)

Pendred Syndrome (5)

PEX1-Related Zellweger Syndrome Spectrum (2)

Phenylalanine Hydroxylase Deficiency (13)

Polyglandular Autoimmune Syndrome Type 1 (2)

Pompe Disease (4)

PPT1-Related Neuronal Ceroid Lipofuscinosis (3)

Primary Carnitine Deficiency (1)

Primary Hyperoxaluria Types 1 and 2 (4)

PROP1-Related Combined Pituitary Hormone Deficiency (1)

Pseudocholinesterase Deficiency (1)

Pycnodysostosis (1)

Rhizomelic Chondrodysplasia Punctata Type 1 (4)

Salla Disease (1)

Segawa Syndrome (1)

Short Chain Acyl-CoA Dehydrogenase Deficiency (1)

Sjogren-Larsson Syndrome (1)

Smith-Lemli-Opitz Syndrome (13)

Steroid-Resistant Nephrotic Syndrome (13)

Sulfate Transporter-Related Osteochondrodysplasia (5)
TPP1-Related Neuronal Ceroid Lipfuscinosis (3)

Tyrosinemia Type I (6)

Very Long Chain Acyl-CoA Dehydrogenase Deficiency (1)

X-Linked Juvenile Retinoschisis (3)

Limitations: As with any medical diagnostic test, genetic testing is risk-reducing, rather than risk-eliminating. Results are based on probabilities, and as such, cannot give 100% definitive conclusions, and cannot diagnose or predict all disease. In addition to the Universal Genetic Test, further testing options may be recommended to your patients. If only one member of a couple is of Ashkenazi Jewish background, a biochemical assay for Tay-Sachs disease can be performed.[1] Individuals of African, Asian, and Mediterranean ancestry are at increased risk for being carriers for hemoglobinopathies and should also be offered carrier testing by CBC and hemoglobin electrophoresis or HPLC.[2]

1. S Gross, BA Pletcher, KG Monaghan. *Carrier screening in individuals of Ashkenazi Jewish descent.* Genetics in Medicine (2008) 10. 54–56.