If you would like more information or would like to receive a copy of Section 766.301-766.316, Florida Statutes, which detail the provisions of the NICA Plan, please call or write:

Florida Birth-Related Neurological Injury Compensation Association
Post Office Box 14567
Tallahassee, Florida 32317-4567
Telephone: (850) 488-8191
Toll Free: 1-800-398-2129
www.nica.com

PEACE OF MIND
For An Unexpected Problem

The birth of a baby is an exciting and happy time. You have every reason to expect that the birth will be normal and that both mother and child will go home healthy and happy.

Unfortunately, despite the skill and dedication of doctors and hospitals, complications during birth sometimes occur. Perhaps the worst complication is one which results in damage to the newborn's nervous system – called a "neurological injury". Such an injury may be catastrophic, physically, financially and emotionally.

In an effort to deal with this serious problem, the Florida Legislature, in 1988, passed a law which created a Plan that offers an alternative to lengthy malpractice litigation processes brought about when a child suffers a qualifying neurological injury at birth. The law created the Florida Birth-Related Neurological Injury Compensation Association (NICA).

Exclusive Remedy

The law provides that awards under the Plan are exclusive. This means that if an injury is covered by the Plan, the child and its family are not entitled to compensation through malpractice lawsuits.

Criteria and Coverage

Birth-related neurological injuries have been defined as an injury to the spinal cord or brain of a live-born infant weighing at least 2500 grams at birth. In the case of multiple gestation, the live birth weight is 2000 grams for each infant. The injury must have been caused by oxygen deprivation or mechanical injury, which occurred in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital. Only hospital births are covered.

The injury must have rendered the infant permanently and substantially mentally and physically impaired. The legislation does not apply to genetic or congenital abnormalities. Only injuries to infants delivered by participating physicians, as defined in s. 766.302(7), Florida Statutes, are covered by the Plan.

Compensation

Compensation may be provided for the following:

- Actual expenses for necessary and reasonable care, services, drugs, equipment, facilities and travel, excluding expenses that can be compensated by state or federal government or by private insurers.
- In addition, an award, not to exceed $100,000 to the infant's parents or guardians.
- Death benefit in the amount of $10,000.
- Reasonable expenses for filing the claim, including attorney's fees.

NICA is one of only two (2) such programs in the nation, and is devoted to managing a fund that provides compensation to parents whose child may suffer a qualifying birth-related neurological injury. The Plan takes the "No-Fault" approach for all parties involved. This means that no costly litigation is required and the parents of a child qualifying under the law who file a claim with the Division of Administrative Hearings may have all actual expenses for medical and hospital care paid by the Plan.

You are eligible for this protection if your doctor is a participating physician in the NICA Plan. If your doctor is a participating physician, that means that your doctor has purchased this benefit for you in the event that your child should suffer a birth-related neurological injury, which qualifies under the law. If your health care provider has provided you with a copy of this informational form, your health care provider is placing you on notice that one or more physician(s) at your health care provider participates in the NICA Plan.

Patient Addressograph

DATE: _____

NAME: _____
LAST FIRST MIDDLE

ID #: _____ HOSPITAL OF DELIVERY: _____

NEWBORN CARE PROVIDER: _____ REFERRED BY: _____

PRIMARY PROVIDER/GROUP: _____

FINAL EDD: _____ ADDRESS: _____

BIRTH DATE: MONTH DAY YEAR AGE: RACE: MARITAL STATUS: S M W D SEP	ADDRESS:
OCCUPATION: EDUCATION: (LAST GRADE COMPLETED)	ZIP _____ PHONE: _____ (1) _____ (2)
LANGUAGE: ETHNICITY:	E-MAIL:
HUSBAND/DOMESTIC PARTNER: PHONE:	INSURANCE CARRIER/MEDICAID #:
FATHER OF BABY: PHONE:	POLICY #:
	EMERGENCY CONTACT: PHONE:

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

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) ☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION ☐ FINAL: _____ MENSES MONTHLY ☐ YES ☐ NO PRIOR MENSES: _____ DATE FREQUENCY: Q _____ DAYS ON BCP AT CONCEPT ☐ YES ☐ NO MENARCHE: _____ (AGE ONSET) hCG + ____/____/____

PAST PREGNANCIES (LAST SIX)

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

MEDICAL HISTORY

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
A. DRUG/LATEX ALLERGIES/ REACTIONS B. ALLERGIES (FOOD, SEASONAL, ENVIRONMENTAL)		
1. NEUROLOGIC/EPILEPSY		
2. THYROID DYSFUNCTION		
3. BREAST DISEASE		
4. PULMONARY (TB, ASTHMA)		
5. HEART DISEASE		
6. HYPERTENSION		
7. CANCER		
8. HEMATOLOGIC DISORDERS		
9. ANEMIA		
10. GASTROINTESTINAL DISORDERS		
11. HEPATITIS/LIVER DISEASE		
12. KIDNEY DISEASE/UTI		
13. VARICOSITIES/PHLEBITIS		
14. DIABETES (TYPE 1 OR TYPE 2)		
15. GESTATIONAL DIABETES		
16. AUTOIMMUNE DISORDERS		
17. DERMATOLOGIC DISORDERS		

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
18. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)		
19. GYN SURGERY		
20. ANESTHETIC COMPLICATIONS		
21. HISTORY OF BLOOD TRANSFUSIONS		
22. INFERTILITY		
23. ASSISTED REPRODUCTIVE TECHNOLOGY		
24. UTERINE ANOMALY/DES		
25. HISTORY OF ABNORMAL PAP		
26. HISTORY OF STI		
27. PSYCHIATRIC ILLNESS		
28. DEPRESSION/POSTPARTUM DEPRESSION		
29. TRAUMA/VIOLENCE		

		PREPREG	PREG	# YEARS USE
30. TOBACCO (AMT/DAY)				
31. ALCOHOL (AMT/WK)				
32. ILLICIT/RECREATIONAL DRUGS (USES/WK)				
33. RELEVANT FAMILY HISTORY				
34. OTHER				

COMMENTS: _____

PATIENT NAME:	BIRTH DATE: / /	ID NO:	DATE: / /

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80		
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)		
3. CONGENITAL HEART DEFECT		
4. DOWN SYNDROME		
5. TAY SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)		
6. CANAVAN DISEASE (ASHKENAZI JEWISH)		
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS		
10. MUSCULAR DYSTROPHY		
11. CYSTIC FIBROSIS*		
12. HUNTINGTON CHOREA		
13. MENTAL RETARDATION/AUTISM		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
16. BIRTH DEFECTS NOT LISTED ABOVE		
17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
IF YES, AGENT(S) AND STRENGTH/DOSAGE		
19. ANY OTHER		

*If a patient has been screened previously, cystic fibrosis screening results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

_____

INFECTION HISTORY	YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
4. PRIOR GBS-INFECTED CHILD		

5. HISTORY OF STIs: GONORRHEA, CHLAMYDIA, HPV, SYPHILIS, PID (CIRCLE ALL THAT APPLY) _____

6. HISTORY OF HIV YES [ ] NO [ ]

7. HISTORY OF HEPATITIS _____

8. OTHER (SEE COMMENTS)

COMMENTS: _____

_____ **INTERVIEWER'S SIGNATURE:** _____

IMMUNIZATIONS	YES (MONTH/YEAR) ___ / ___	NO	IF NO, POSTPARTUM VACCINE INDICATED?	IMMUNIZATIONS	YES (MONTH/YEAR) ___ / ___	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD				HEPATITIS A (WHEN INDICATED)			
INFLUENZA*				HEPATITIS B (WHEN INDICATED)			
VARICELLA*				MENINGOCOCCAL (WHEN INDICATED)			
MMR*				PNEUMOCOCCAL (WHEN INDICATED)			

*All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

INITIAL PHYSICAL EXAMINATION

DATE ___ / ___ / ___ WEIGHT: ___ HEIGHT: ___ BMI: ___ BP: ___

1. HEENT	[ ] NORMAL	[ ] ABNORMAL	12. VULVA	[ ] NORMAL	[ ] CONDYLOMA	[ ] LESIONS
2. TEETH	[ ] NORMAL	[ ] ABNORMAL	13. VAGINA	[ ] NORMAL	[ ] INFLAMMATION	[ ] DISCHARGE
3. SYMPTOMS SINCE LMP	[ ] NORMAL	[ ] ABNORMAL	14. CERVIX	[ ] NORMAL	[ ] INFLAMMATION	[ ] LESIONS
4. THYROID	[ ] NORMAL	[ ] ABNORMAL	15. UTERUS SIZE	___ WEEKS		[ ] FIBROIDS
5. BREASTS	[ ] NORMAL	[ ] ABNORMAL	16. ADNEXA	[ ] NORMAL	[ ] MASS	
6. LUNGS	[ ] NORMAL	[ ] ABNORMAL	17. RECTUM	[ ] NORMAL	[ ] ABNORMAL	
7. HEART	[ ] NORMAL	[ ] ABNORMAL	18. DIAGONAL CONJUGATE	[ ] REACHED	[ ] NO	___ CM
8. ABDOMEN	[ ] NORMAL	[ ] ABNORMAL	19. SPINES	[ ] AVERAGE	[ ] PROMINENT	[ ] BLUNT
9. EXTREMITIES	[ ] NORMAL	[ ] ABNORMAL	20. SACRUM	[ ] CONCAVE	[ ] STRAIGHT	[ ] ANTERIOR
10. SKIN	[ ] NORMAL	[ ] ABNORMAL	21. SUBPUBIC ARCH	[ ] NORMAL	[ ] WIDE	[ ] NARROW
11. LYMPH NODES	[ ] NORMAL	[ ] ABNORMAL	22. GYNECOID PELVIC TYPE	[ ] YES	[ ] NO	

COMMENTS (Number and explain abnormals): _____

_____ **EXAM BY:** _____

KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

GENETIC TESTING

Please call your insurance company prior to your next appointment to ensure that you are covered for these labs. The cpt codes for the labs are:

CYSTIC FIBROSIS 81220

FRAGILE X SYNDROME 81243

SPINAL MUSCULAR ATROPHY 81401

If you do not call your insurance company to see your coverage and you consent for the tests you will be responsible for any charges that may occur if you do not have coverage.

AS PER AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY IT IS RECOMMENDED TO HAVE THESE TESTS, SOME INSURANCE COMPANIES ARE SAYING THE TESTS ARE EXPERIMENTAL AND REFUSE TO PAY FOR THESE TESTS, WHCH WILL RESULT IN THE LAB SENDING YOU A BILL AND BECOMING YOUR RESPONSIBILITY WITH THE LAB. ONCE TESTING IS INITIATED, CANCELLATION IS NOT POSSIBLE. YOU ARE RESPONSIBLE FOR ALL CHARGES FOR TESTING AND WILL BE CONTACTED BY THE LAB FOR PAYMENT IN THE EVENT YOUR HEALTH PLAN DOES NOT REIMBURSE FOR THE TESTS OR RECEIVE A RESPONSE FROM YOUR HEALTH PLAN.

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1040 Weston Road, Suite 105 • Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027

KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

Upper Respiratory Colds:
NO Advil
NO Nyquil
Tylenol, 1-2 tablets every 4-6 hours
Saline Nasal Sprays for Congestion – Ocean Air
Sudafed or Actifed, 1 tablet every 4-6 hours as needed
Robitussin DM or Triaminic, 2 teaspoons every 4-6 hours for cough
Gargle with warm salt water
Lozenges for cough or sore throat
Vicks or other Methol Ointments
Vaporizers, Hot Showers, or Humidification for congestion
Warm, moist compresses on the face for sinus pain
Plenty of Fluids / Warm Tea

Morning Sickness:
Acupressure Point Wristbands
Vitamin B6, 50 mg twice a day
Ginger Ale
Chamomile or Peppermint Tea
Papaya Chewable Tablets
Dry Crackers
Emetrol or Emecheck (over the counter)

Heartburn
Maalox
Tums
Mylanta
Pepcid AC

Diarrhea
Lomotill
Kaopectate
Immodium

Constipation:
8-10 glasses of water a day
Fruits and Vegetables
Bran
Warm Fluids
Prune Juice
Metamucil, one rounded teaspoon in 8 oz. of liquid for 2-3 days

Allergies
Zyrtec
Benadryl

Insomnia (difficulty sleeping
Melatonin
Unisom
Benadryl

Hemmoroids:
Tucks
Metamucil
Bran
Pericolace Stool Softener
Annusol

Heartburn:
Maalox
Tums
Mylanta
Pepcid AC

Diarrhea:
Lomotil
Kaopectate
Immodium

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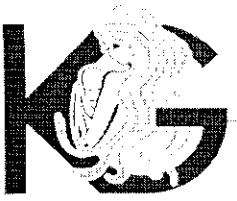

KOMPAL GADH, M.D.

ADVANCED OB/GYN INSTITUTE

CIRCUMCISIONS

All circumcisions will be performed prior to you being discharged from the hospital, provided there are no medical problems and the clearance from the pediatrician is obtained.

If you have commercial insurance, you are required to make financial arrangements with the office prior to delivery. The price is $325.00. We will bill your insurance and after the insurance pays, the $325.00 will be refunded to you.

If you are a self-pay patient or have Medicaid coverage you are required to make financial arrangements with our office prior to delivery. Circumcisions are not a covered benefit with Medicaid. The price is $325.00.

Thank you for your attention in this matter.

_____ _____

Patient Name Witness

_____ _____

Signature Date

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KOMPAL GADH, M.D.

ADVANCED OB/GYN INSTITUTE

INFORMED CONSENT OF MY PHYSICIAN PARTICIPATION IN THE

FLORIDA BIRTH RELATER NEUROLOGICAL INJURY ASSOCIATION (NICA)

I hereby acknowledge that:

1. I have been advised that Kompal Gadh M.D., LLC is participating in the NICA Plan;
2. I have been furnished with copy of the NICA brochure which describes the NICA plan and my rights and limitations under the NICA Plan;
3. I understand that the no-fault aspects of the NICA Plain will serve as exclusive remedy for injury which qualifies under the NICA Plan and that as a result I am forfeiting any and all rights to bring legal action in a Court of Law for damage in connection with such injuries;
4. Any questions I may have had regarding my physician's participation in the NICA Plan and my rights and limitations under the NICA Plan have been answered to my satisfaction;
5. I hereby consent to obstetrical services having been given notice pursuant to Florida Statute 766.316 by my physician of the applicability of the NICA upon such obstetrical services.

Date this _____ **day of** _____, **20** _____

Patient's Name (Please Print): _____

Patient's Signature: _____

Witness Name (Please Print): _____

Witness Signature: _____

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KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

CONSENT TO CARRIER TESTING CYSTIC FIBROSIS

Cystic Fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. Symptoms of CF vary but include lung congestion, pneumonia, diarrhea, and poor growth. Most people with CF have severe medical problems and some die at a young age. Others experience few symptoms and may be unaware of having CF. there is no cure for CF at this time and it does not affect the learning process in children. Many people with CF have died at a very young age in the past. As a result of scientific advantages these days many with the disease are living into their 20's and 30's.

WHAT ARE THE CHANCES OF MY BABY HAVING CYSTIC FIBROSIS?

You can have a child with CF even if there is no family history. Carrier frequency in the U.S. is 1 in 30 on average and varies by ethnicity. CF testing can help determine if you are a carrier and at risk to have two altered genes. Most people have two normal copies of the CF gene.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause CF.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.
- **We are not aware if your insurance covers this test, therefore you may get a bill from the lab**

☐ **I want** CF carrier testing ☐ **I do not want** CF carrier testing

_____ _____

Patient Signature Date

_____ _____

Witness Date

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KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

CONSENT CARRIER TESTING FRAGILE X SYNDROME

The most common inherited cause of mental retardation is Fragile X syndrome. Symptoms involve developmental delay, mental retardation, autism and hyperactivity. Women who are carriers are at risk to have a child with mental retardation. Fragile X syndrome affects primarily boys and approximately 1 in 260 women. It can also occur in all ethnicities.

Inheritance
If the mother is a carrier, there is a 50% chance the child will have Fragile X syndrome.

Consent
If I am a carrier, prenatal testing is available to find out whether or not the baby has inherited the abnormal Fragile X gene.

Referral
We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause Fragile X syndrome.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.
- **We are not aware if your insurance covers this test, therefore you may get a bill from the lab.**

☐ **I want** Fragile X carrier testing ☐ **I do not want** Fragile X carrier testing

_____ _____
Patient Signature Date

_____ _____
Witness Date

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KOMPAL GADH, M.D.
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CONSENT CARRIER TESTING SPINAL MUSCULAR ATROPHY

Spinal Muscular Atrophy (SMA) is the most common inherited cause of early childhood death. It affects 1 in 35 to 1 in 117 people in the U.S. and varies by ethnicity. SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling head or neck movements, crawling and walking. The most common form affects infants in the first month of life and can cause death between 2-4 years of age. Less commonly the condition starts later and people can survive into adulthood. SMA does not affect the learning process and there is no cure or treatment.

Inheritance
If the test shows you are a carrier of SMA, the next step is for your partner to have carrier testing performed. Both parents must be carriers for the baby to be at risk for SMA. If your partner has a negative test result and no family history of SMA the chance of your baby having SMA is less than 1%. If both parents are carriers, there is 25% or a chance of 1 in 4 to have a child with SMA.

Referral
We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause SMA.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.
- **We are not aware if your insurance covers this test, therefore you may get a bill from the lab.**

☐ **I want** SMA carrier testing ☐ **I do not want** SMA carrier testing

_____ _____
Patient Signature Date

_____ _____
Witness Date

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KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

HIV TEST IN PREGNANCY
CONSENT FORM

Information is provided in accordance to Florida Law

HIV/AIDS is an important health concern for pregnant women because she can pass the HIV virus to her baby during pregnancy or childbirth or through breastfeeding. HIV testing is recommended as a routine test for all pregnant women. It is much better for a woman to know her HIV status as early in pregnancy as possible so she can make important decisions about health care and breast feeding. Tests are available to detect antibodies for HIV that are safe and can be done along with other prenatal blood tests.

A positive test does not necessarily mean that you have AIDS or that you will become ill with AIDS. A positive test does mean that can infect others with the virus and that you must take precautions to prevent spreading the infection. If your test is positive, you will again knowledge and understanding of an important medical condition and be able to inform your sexual partner (s) and health care provider (s).

There are medications that may help a woman who is pregnant and has HIV to reduce the chance of passing HIV to her baby. If a pregnant women is HIV-positive and does not get treatment, her baby has about a 25% chance of getting HIV from her. But if an HIV-positive pregnant woman receives appropriate medication as late as during the delivery of her child, she can reduce the risk of transmission by at least 50%.

A negative test result may mean that you have not been infected with HIV-1. If you have been engaging in behaviors that put you at risk, you may want to be retested in approximately six months. A negative test may also mean that your body has not had time to develop antibodies to HIV-1 and that you have an early infection.

Because treatment is so effective in preventing babies from getting HIV, Florida law and regulations require that every pregnant women be counseled about HIV and the benefits of testing and be offered and HIV test along with the standard blood test for syphilis and hepatitis B surface antigen (HBsAg). Testing must be offered at the time of the first examination relating to the current pregnancy and again at 28 to 32 weeks gestation.

Although HIV testing is routinely performed as part of the antenatal testing protocol, you have the right to refuse the test. The decision to have testing for syphilis, hepatitis B, or HIV is voluntary and you may withdraw your consent at any time.

Your physician will answer any questions you may have about HIV testing. If you are pregnant and you test positive for HIV, your physician can provide the care you need and information about services and options available to you. Your physician can tell you the risk of passing HIV infection to your baby, about medications given during pregnancy that can significantly reduce the risk of passing HIV to your baby, and the medical care available for babies who may be infected with HIV.

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KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

CONSENT TO HIV-1 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the rules have been explained to me. I understand that if the results indicate that if the results indicate that my blood contains antibody to HIV, it means that I may have been infected with the HIV virus, which is believed to cause AIDs (Acquired Immune Deficiency Syndrome).

AT FIRST PRENATAL VISIT

☐ I authorize my healthcare providers to collect one or more blood specimen form me at the time of my first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV- 1 (human immunodeficiency virus). This is the virus which has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report test results to me in person and not by telephone or by mail. At that time, I will have the opportunity to receive counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of, exposure to, and transmission of HIV has been made available to me.

Consent to Release

I understand that the test results will be confidential and will not be disclosed to any person without my consent unless permitted or required by law, I also consent to the release of the test results to _____

☐ REFUSAL OF HIV-1 ANTIBODY TESTING

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered and with full knowledge of the consequences, I refuse to give my consent for HIV testing.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Name of Patient (Please Print)

IN THIRD TRIMESTER

☐ Authorization For Repeat HIV Testing In Third Trimester Of Pregnancy

I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the retest is performed and will provide me with the test results.

☐ I Decline Repeat HIV Testing In Third Trimester of Pregnancy

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered and with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Name of Patient (Please Print)

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KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

CONSENT FORM FOR FETAL CHROMOSOMAL SCREEN: FIRST AND SECOND TRIMESTER SCREEING

Babies may be affected with chromosome abnormalities, the most common being Down Syndrome, a disorder that leads to intellectual disabilities and other birth defects. Generally, risk of chromosome abnormalities becomes greater as the age of the expectant mother increases. For mothers 35 years of age or more at the time of delivery, the standard recommendation is to offer a genetic amniocentesis: the diagnostic option. Screening options are however also available.

Because younger mothers can also have a baby with chromosome abnormalities, a non-invasive screening test using a blood sample is generally offered to those under the age of 35. These tests, commonly known as multiple marker screening, is done during the first and/or second trimester of the pregnancy. They can detect up to 92% of babies affected with Down syndrome, provides information about the baby's risk of Trisomy 18 (a chromosomal disorder that causes severe intellectual disabilities and birth defects), as well as risk of open neural tube defects (ONTD-occur when the developing baby's spine or skull does not form completely , as in spina bifida).

Each option has relative advantages and disadvantages. Your options are as follows:

Multiple marker screening:

First Screen

This screening tests includes a sonogram to measure the amount of fluid accumulation at the back of the Baby's neck (Nuchal Translucency) and one blood sample. FirstScreen helps to identify babies at Increased risk of having Down syndrome or Trisomy 18, but does **not** identify risk for ONTD (spina bifida). Another blood sample should be taken in the second trimester to analyse the risk of ONTD. FirstScreen detection rates for Down syndrome and Trisomy 18 are lower than IntegratedScreen, but the results are available earlier in the pregnancy.

Integrated Screen

This screening test combines the measurement of the Nuchal Translucency (described above) with two blood samples: between 11-13 weeks and 15-20 weeks. The result of this screen will not be available until after the second blood sample has been analyzed. This screen has a high detection rate for Down syndrome, Trisomy 18 and Open Neural Tube Defect (ONTD), however there is a false positive rate of %. False negative results have also been reported.

Quad Screen (AFP4)

This is a single blood test obtained at approximately 16-20 weeks. Detection rates for Down syndrome and Trisomy 18 are lower than with the Integrated Screen, but detection rates for ONTD are the same.

-Cell free DNA (NIPS)

The newest screening test available is NIPS or cell free DNA. It isolates and analyses DNA from the placenta that is circulating in the mother's blood. It is the most reliable blood test for detecting Down syndrome, Trisomy 18 and Trisomy 13, with a false positive rate of approximately 0.5%. False negative results have also been reported. At the present time, insurance companies may only reimburse for this testing for patients who have an increased risk based on age, family history or ultrasound findings.

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-No screening
You may choose not to undergo any screening test. Some patient who feel that they would not intervene if the baby should have a problem may prefer this option.

What if your tests shows an increased risk?
It is important to understand that all screening tests are limited, a result that is within the normal range does not necessarily mean that there are no chromosomal abnormalities present. It means that the risk of a chromosome problem is low. Also a result that shows increased risk does not mean that the baby actually has a chromosomal abnormality. Mothers whose test results show an increased risk will be offered further evaluation which will include invasive testing (amniocentesis) which can determine whether the baby has a chromosomal abnormality or not.

-Amniocentesis
This is a diagnostic test and is the standard option for mothers who are 35 years old or more. This is also the recommended option for mothers who have had a previous baby affected with a chromosome anomaly or ONTD, It involves the removal of a sample of the amniotic fluid for analysis. As it is an invasive test, it has a small risk of complications.

CONSENT
I understand that there are benefits and limitations for any test, including false positives and false negative results. All my questions have been satisfactorily answered. I understand that testing is voluntary and I may decline testing at any point. **I understand that my insurance company may not cover these services and I agree to provide payment.**

Your choices:

-If you are 35 years-old or more at the time of delivery

I choose:
___Integrated Screening
___Cell-free DNA(Panorama/Harmony)
___None

-If you are less than 35 years-old at time of delivery.

I choose:
___First Screen
___Integrated Screen
___Multiple Marker Screen
___Cell Free DNA(Panorama/Harmony)
___None

_____ _____
Patient Name (Print) Date

_____ _____
Patient Signature Witness

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CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to **NAME, LLC** to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by **NAME, LLC** and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

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NAME, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold **NAME, LLC**, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold **NAME, LLC** responsible for instances of these violations.

Signature: _____ Date: _____