My OB/GYN
"Women Specialists For Women"

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

Helen Salsbury, M.D, FACOG
Selena Hodgers, ARNP – BC

PATIENT INITIAL INTAKE AND SELF HISTORY - Page 1

Date of Appointment: _____

Name: _____ **Date of Birth:** _____

Reason for today's visit:

ALLERGY HISTORY ☐ None ☐ Medication (list below) ☐ Latex ☐ Seasonal ☐ Other:

Medication	Reaction	Medication	Reaction

CURRENT MEDICATIONS ☐ **I give my consent for My Ob/Gyn LLC to electronically obtain my medication history**

PHARMACY _____ **Phone:** _____ **Fax:** _____

Medication	Dose	Medication	Dose

PREVIOUS TESTS

Last Pap Smear date: _____ ☐ Normal ☐ Abnormal, explain: _____
Last Mammogram: _____ ☐ Normal ☐ Abnormal, explain: _____
Last Bone Density: _____ ☐ Normal ☐ Abnormal, explain: _____
Last Colonoscopy: ☐ Normal ☐ Abnormal, explain:

PERSONAL HABITS

Tobacco Use: ☐ Never
☐ Former Cigarette, Packs/Day ____ # Years ____ Yr Started ____ Yr Quit: ____
☐ Current Cigarette, Packs/Day ____ # Years ____ Yr Started ____
☐ Other Tobacco, specify _____
Alcohol Use: ☐ None ☐ Social/Holiday ☐ Weekly, specify _____ ☐ Daily, specify _____
Exercise: _____
Special Diet: ☐ None ☐ Vegetarian ☐ Kosher ☐ Other _____
Recreational Drug Use: ☐ Never ☐ In Past ☐ Currently using ☐ Rec'd treatment for substance abuse ☐ IV Drug Use

SURGICAL HISTORY

Year	Surgery with Diagnosis or Problems	Year	Surgery with Diagnosis or Problems

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PAST MEDICAL HISTORY

Problem	Now	Past	N/A	Notes	Problem	Now	Past	N/A	Notes
Anemia	☐	☐	☐		Abnormal Vaginal Bleeding	☐	☐	☐	
Asthma	☐	☐	☐		Abnormal Pap Smears / HPV	☐	☐	☐	
Breast disease, specify	☐	☐	☐		Heart disease/murmur	☐	☐	☐	
Cancer, specify	☐	☐	☐		Diabetes or Gestational Diabetes	☐	☐	☐	
Endometriosis	☐	☐	☐		Gastrointestinal disorder, specify	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐		Irritable bowel syndrome	☐	☐	☐	
High blood pressure	☐	☐	☐		Pelvic Inflammatory Disease	☐	☐	☐	
Osteoporosis	☐	☐	☐		Kidney Infection/stones	☐	☐	☐	
Ovarian Cysts	☐	☐	☐		Gallbladdder Problems	☐	☐	☐	
Stroke CVA TIA	☐	☐	☐		Thyroid Disease, specify	☐	☐	☐	
Uterine Abnormalities	☐	☐	☐		Blood Clots/Thromboembolism	☐	☐	☐	
Uterine Fibroids	☐	☐	☐		Chronic Constipation or diarrhea	☐	☐	☐	
Depression	☐	☐	☐		Chronic Headache or Migraines	☐	☐	☐	
Liver Disease, specify	☐	☐	☐		Chronic lower back pain	☐	☐	☐	

Accidents, Injuries or Fractures:

OTHER:

OTHER:

INFECTION HISTORY

Problem			Date/Notes	Problem			Dates/Notes
Yeast	☐ Y	☐ N		Mononucleosis	☐ Y	☐ N	
Bacterial Vaginosis	☐ Y	☐ N		Gonorrhea	☐ Y	☐ N	
Urinary Tract Infections	☐ Y	☐ N		Chlamydia	☐ Y	☐ N	
Herpes	☐ Y	☐ N		Trichomoniasis	☐ Y	☐ N	
Genital Warts	☐ Y	☐ N		Syphilis	☐ Y	☐ N	
Pelvic Infection	☐ Y	☐ N		HIV/AIDS	☐ Y	☐ N	
Hepatitis B	☐ Y	☐ N		Tuberculosis	☐ Y	☐ N	
Hepatiis C	☐ Y	☐ N		Chicken Pox	☐ Y	☐ N	

Do you / your partner have a history of STD, IV drug usage or male partner having sex with another man? ☐ N ☐ Y explain

If yes to the above question, do you use condoms consistently? ☐ Yes ☐ No, If not explain _____

GYNECOLOGIC HISTORY

Age at first menstrual period _____

Do you still have periods? ☐ Yes ☐ No

When was the first day of your last period? _____

Are they regular? ☐ Yes ☐ No, explain: _____

Menstrual flow is ☐ Heavy ☐ Moderate ☐ Light

How many days are in between your menstrual periods? _____ days

How many days long is your typical period? _____ days

Painful Periods? ☐ No ☐ Yes, describe: _____

Were you exposed to DES in utero? ☐ Yes ☐ No ☐ Uncertain

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SEXUAL HISTORY

Are you currently in a sexual relationship? ☐ Yes ☐ No ☐ (Virgin)

Steady Relationship? ☐ Yes, How long? _____

☐ NO How many partners in the last 12 mos? _____ In lifetime? _____

Sexual Preference ? ☐ Male ☐ Female ☐ Both

Last Intercourse date: _____

Are you planning a pregnancy in the next 12 months? ☐ Yes ☐ No

Do you have a history of rape? ☐ No ☐ Yes, if comfortable with details, please explain

CONTRACEPTION HISTORY

Current Birth Control: ☐ None, because ☐ Trying to get pregnant ☐ Vascectomy ☐ Tubes tied ☐ Post Menopausal

☐ Yes, my method is _____

Consistent in use? No☐ Yes☐ How long have you been using this method?

History of IUD / Implant? ☐ No ☐ Yes What Type? ☐ Paragard ☐ Mirena/Skyla ☐ Implanon ☐ Nexplanon

When and why discontinued?

OBSTETRIC HISTORY G: P:

Total #Pregnancies _____ #Full Term Vaginal _____ #C-Sections _____ #Premature _____ Total Living _____

#Miscarriages _____ at _____ weeks, with or without D&C, complications _____

#Abortions _____ at _____ weeks, complications _____

Year	Vaginal or Cesarean	Weight	Problems encountered before, during or after birth

FAMILY HISTORY ☐ Unknown, I am adopted

Mother ❒ Living ❒ Deceased, Cause _____ Father: ❒ Living ❒ Deceased, Cause _____

Siblings: Number Living _____ Number Deceased _____ Cause(s) _____

Place an "X" in each box for each problem	Heart Disease	Hyper-tension	Stroke	Diabetes (specify type)	Uterine, Cervical, Ovarian Cancer	Breast Cancer	Colon Cancer	Osteo-porosis	Fibroids	Other Significant Medical Problems
Mother										
Father										
Brother(s)										
Sister(s)										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Maternal Aunt(s)										
Paternal Aunt(s)										
Uncle(s)										
Children										

If yes for any ***Breast Cancer***, has any family member don the BRCA test? _____

What age was the breast cancer discovered for each family member? _____

Does any family member have: ❒ Sickle Cell ❒ Bleeding disorder ❒ Genetic Disorder ❒ Twins ❒ Alcoholism ❒ Psychiatric

Explain any other pertinent medical problems in your family _____

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REVIEW OF SYSTEMS

Please (✔) if you have experienced any of the following symptoms in the last 3 months

Symptom	✓	Notes	Symptom	✓	Notes
Chronic fatigue			Nausea or vomiting		
Fevers			Poor appetite		
Difficulty falling or staying asleep			Abdominal bloating/fullness		
Unintentional weight loss			Heartburn		
Unintentional weight gain			Constipation		
Rash			Diarrhea		
Itching			Blood in stools		
Vaginal or vulvar ulcers or fissures			Pain with bowel movements		
Itchy eyes			Urinary frequency		
Sore throat			Urgency (sudden urge to urinate)		
Mouth sores or ulcers			Urine leaking		
Bleeding gums			Pain with urination		
Chest pain			Blood in urine		
Irregular heart beat			Incomplete bladder emptying		
Ankle/foot swelling			Night time urination (>2/night)		
Shortness of breath			Vaginal discharge		
Chronic cough			Painful periods		
Wheezing			Painful intercourse		
Headaches			Vaginal dryness		
Dizziness			Irregular bleeding		
Low attention/difficulty concentrating			Breast Pain		
Muscle or joint pain			Breast mass		
Body aches and stiffness			Nipple discharge		
Leg pain			Hot flashes		
Back pain			Night sweats		
Trouble walking			Excess hair growth		
Other Symptoms					

RECENT VACCINATIONS

Last Flu Shot _____ Last Tdap _____ HPV vaccination _____ Last Pnuemonia _____

SAFETY

1) Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Y N _____

2) Do you feel safe in your current relationship? Y N _____

3) Is there a partner from a previous relationship who is making you feel unsafe now? Y N _____

FOR MEDICARE PATIENTS, PLEASE ANSWER THE FOLLOWING

1) Pap smear in the last 7 years? N Y _____

2) Abnormal Pap smear? N Y when? _____

3) Ever tested positive for the HIV virus? N Y _____

4) Sexual activity before 16 years old? N Y _____

5) More than 5 sexual partners in lifetime? N Y _____

6) Mother take DES when pregnant with you? N Y _____

COMPLETED BY: **REVIEWED BY:**

PATIENT SIGNATURE _____ Form Complete Date _____ PROVIDER SIGNATURE _____ DATE _____

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NEW PREGNANCY HISTORY

Date of Appointment: _____

Name: _____ **Date of Birth:** _____

MENSTRUAL HISTORY

When was the first day of your last period? _____ ☐ Unknown ☐ Approximate Date ☐ Definate Date

Previous menstrual period date _____ Menses Frequency, every _____ days Menses typically heavy? ☐ Y ☐ N

Date of Last Pap _____ On Birth Control pill at conception? ☐ Y ☐ N Age menses started _____

MEDICAL HISTORY (✔) all positive

	Diabetes			Neurologic / Epilepsy	
	High Blood Pressure			Pulmonary (TB / Asthma)	
	Heart Disease			History IUD use	
	Autoimmune Disorder			Infertility	
	Kidney Disease			Hepatitis / Liver Disease	
	Urinary Tract Infections			History Blood Transfusion	
	Thyroid Dysfunction			Anesthetic Complications	
	Breast Disease			Psychiatric	
	Cancer			Variscosities / Phlebitis	
	Uterine Anomolies			D (RH Sensitized)	
	History Abnormal Pap			Depression/Post Partum Depression	

Relevant Family History

Operations / Hospitalizations (year and reason)

 # Miscarriages _____ at _____ weeks, with or without D&C, complications _____

 # Abortions _____ at _____ weeks, complications _____

Infection History (✓) all positive

☐ Hepatitis B Immunized ☐ Live with someone with / exposed to TB ☐ History STI

☐ Self or Partner with genital herpes ☐ Rash or viral illness since last menses ☐ Other _____

	Pre-Pregnancy Amt/Day	Pregnancy Amt/Day	#Yrs Used	Notes
☐ Tobacco				
☐ Alcohol				
☐ Drugs				

GENETICS SCREENING - Include patient, baby's father, or anyone in either family (✓) all positive

	Age > 36 by estimated date of delivery		Huntinton's Chorea
	Recurrent pregnancy loss or still birth		Maternal Metabolic Disorder
	Cystic Fibrosis		Neural Tube Defect
	Congenital Heart Defect		Thalassemia
	Down Syndrome		Origin of Italian, Greek, Mediterranean or Asian
	Tay-Sachs		Other origin - French-Canadian, Jewish, African
	Canavan Disease		Other Inherited Genetic or Chromosomal Disorder
	Sickle Cell Trait or Disease		Mental Retardation / Autism
	Hemophillia or other Blood Disease		If Yes, was person tested for Fragile X?
	Muscular Dystrophy		Either parent had a child with Birth Defects not listed above

Please answer the following questions:

1) In the past year, or since you've been pregnant, have you been hit, slapped, kicked or physically hurt by someone? Y N
2) Are you in a relationship with a person who threatens or physically hurts you? Y N
3) Has anyone forced you to have sexual activities that made you feel uncomfortable? Y N

PATIENT SIGNATURE _____ Form Complete Date _____ PROVIDER SIGNATURE _____ DATE _____

My Ob/Gyn, LLC 601 NW 179th Ave. #102 Pembroke Pines, FL 33029 **Phone:** (954) 436-2867 (954-4-DOCTOR) **Fax:** (954) 442-5167

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Patient Demographic Page

Date of Appointment: _____

Name: _____ **Date of Birth:** _____

Address: _____ **Email** _____

Who told you about this office? _____

Primary Physician: _____ **Phone:** _____ **Fax:** _____

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married, Husband/Partners Name:

Racial Background: ☐ White ☐ Black or Afro American ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Religion: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Hindu ☐ Muslim ☐ Christian ☐ Jehovah ☐ Other: _____

Preferred Language _____

Occupation: _____ Education: ☐ High School ☐ College ☐ Graduate Degree ☐ Other:

SS # _____

Spouse Name and DOB _____

1) With this consent, the office of My Ob/Gyn LLC may contact me as I indicate for purposes such as insurance items or anything pertaining to my clinical care, including laboratory results.

OK to contact me by any of the following methods

Home Phone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back information only
- ☐ OK to leave limited info with family member

Cell Phone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back information only

Work Phone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back information only

OK to Mail, Email and / or Text (please circle)

2) Authorization for disclosure or obtaining your personal medical information

☐ I authorize the disclosure of my medical information to: (I can revoke this authorization anytime)

_____ relationship _____ Auth Expires _____

EMERGENCY CONTACT INFORMATION. **(Please list at least two)**

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

_____ _____

Signature of Patient or Legal Guardian Date

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Financial Policies and Notices Forms

Notice of Privacy Practices - Short Form

Keep this form for your records. Acknowlegement of your receipt of this notice is located on the Authorizations and Notices page of the financial policy.

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPPA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your demographic information. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

Treatment	Appointment Reminders	Release of Information to Family and Friends
Payment	Treatment Options	Disclosure Required by Law
Healthcare Operations	Health-related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Treatment	Health Oversight Activities	Lawsuits and Similar Proceedings	Law Enforcement
Payment	Organ & Tissue Donation	Serious Threats to Health or Safety	Research
Healthcare Operations	National Security Inmates	Workers' Compensation	

What are your rights concerning your Individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

To obtain more detailed information, request our 7 page full Privacy Policy from the front desk receptionist.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Privacy Officer for My Ob Gyn LLC 601 NW 179th Avenue, Suite 102 Pembroke Pines, FL 33029 (954) 436-2867 x4

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Financial Policies and Notices Forms

Financial Policy for My ObGyn, LLC

This page for patient reference

This financial policy contains important information regarding your financial responsibilities in return for medical services. These policies are important as we are committed to providing you with the best possible care while also controlling administrative costs. The individual receiving the service is the responsible party for all outstanding payments. In the case of a minor, the custodial parent(s) is considered the responsible party.

Patients with insurance:

Our practice participates with many health insurance companies; however, our relationship is with you and not your insurance company. Therefore, your responsibilities include:

- Keeping us updated with any type of insurance change
- Being prepared to pay your co-pay, coinsurance or deductible in full at the time services are rendered. What you pay in the office may or may not be the final total. Your final responsibility will be determined after your insurance company has reviewed the claim sent from our office.
- If you have a HMO that requires a referral for services, it is your responsibility to obtain this referral prior to your visit.
- For medical care that is not covered by your insurance, it is your personal responsibility to pay for services rendered in full at the time of service.
- For rejected claims and any claims not paid by your insurance, all charges will become the patient's responsibility and immediately due and payable.
- It is your responsibility to follow-up with your insurance company for any unpaid charges and secure payment in a timely manner. Payment is expected in full 60 days after we file with the insurance If your insurance does not pay within this time period, it will then be due and payable by you, the patient.

Patients without insurance or out-of-network insurance plan:

Full payment is due at the time of service unless other mutually agreed upon arrangements have been made with our billing staff.

Patients with Medicare/Medicaid:

We follow Medicare/Medicaid guidelines. If Medicare does not cover a service and you signed an "Advance Beneficiary Notice" for that service, you may be billed for the non-covered service.

Prompt payment statement:

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly.

Payment Plans and Collections:

If you are having financial hardship and cannot pay your entire bill, we encourage you to contact our billing staff to discuss payment arrangements. We are here to help you.

If your account remains delinquent and we have not established payment options or you are delinquent with your payment plan or you have moved without giving us your forwarding information and your account is delinquent, please be aware that your account will be turned over to a collection agency and an additional fee will be added to your account balance.

Other fees:

$32.00 Returned check fee
$25.00 No-show fee
$10.00 per page form completion fee not exceeding $30.00
$5.00 monthly charge for balances over 60 days old
$50.00 charge for sending to collection company

We accept Checks/Cash, VISA®, MasterCard®, American Express® and Discover Card®

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Financial Policies and Notices Forms

Patient Signature Page

Name: _____ **Date of Birth:** _____

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of ***My Ob/Gyn, LLC*** financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to ***My Ob/Gyn, LLC*** , any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to ***My Ob/Gyn, LLC*** for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to ***My Ob/Gyn, LLC*** are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices of ***My Ob/Gyn, LLC.***

NOTICE OF MALPRACTICE INSURANCE

Dr. Helen Salsbury has elected not to carry Medical Malprace Insurance which is permitted under Florida Law. However, Florida Law also stipulates that the uninsured doctor agree to satisfy adverse judgements up to the minimum amounts pursuant to S-458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Relationship to Patient

My OB/GYN
"Women Specialists For Women"

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Selena Hodgers, ARNP – BC

Name: _____ **Date of Birth:** _____

NICA PARTICIPATION NOTICE for Helen Salsbury, MD

NOTICE TO OBSTETRIC PATIENTS

(See Section 766.316, Florida Statutes)

I have been furnished information by HELEN SALSBURY, M.D., prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Helen Salsbury, MD is a participating physician in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, PO Box 14567 Tallahassee, Florida 32317-4567. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _____ day of _____, 201__

_____
Signature of Patient

Attest: _____
Printed Name of Patient)

_____
Nurse or Physician

_____
Date

This form is informational only, and each person, participating physician or hospital should contact their own attorney to ensure compliance with Section 766.316, Florida Statutes

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ROUTINE OBSTECTRIC LABS

Name: _____ **Date of Birth:** _____

The following chart lists the typical laboratory tests taken at My ObGyn, LLC for pregnant patients. This list is not all inclusive as some patients may require more testing due to certain medical conditions. Some tests only need to be performed once-in-a-lifetime. These tests are the cystic fibrosis, rubella, hemoglobin evaluation (includes sickle cell) and blood type. If you had any of these tests done with a previous provider, you will need to obtain these records and give to us if you do not want them repeated. The cystic fibrosis is the most expensive one. Please advise our medical assistant of your intentions before she draws your blood. Some insurances may apply the cost of these tests to your deductible. If this is true for your insurance, then you will receive a bill from the laboratory for payment.

	First Visit / 6-10 wks	24-28 wks	32-34 wks
General Testing			
CBC *Check for anemia and/or detect low platelet count*	X	X	X
ABO / Rh *Check for potential incompatibility in blood type between mother and fetus*	X		
Antibody *Rh factor antibodies (repeated at 28 wks if RhoGam is needed)*	X	X	
Pap with Chlamydia / Gonorrhea *Screen for cervical cancer and some STDs*	X		
Infectious Diseases			
Rubella (German Measles) *Check for immunity to the virus, which can cause birth defects*	X		
Syphilis (also Chlamydia & Gonorrhea, if no pap was taken) *Check for STD infections, which can cause miscarriage / infect the baby during delivery*	X		X
Hepatitis B *Check for STD infections that can infect the baby during delivery*	X		X
Hepatitis C *Check for STD infections that can infect the baby during delivery*	X		
HIV *So steps can be taken to reduce likelihood of transmission to the baby*	X		X
HSV I & II *Check for STD infections that can infect the baby during delivery*	X		
Toxoplasma *Check for infection with toxoplasmosis that can cause birth defects*	X		
Group B streptococcus *Detect infection, which can harm the baby during birth & infect the mother's uterus, urinary tract, & incisions made during a cesarean section*			X
Inherited Diseases			
Cystic Fibrosis (CF) *Check carrier status for CF*	X		
Hemoglobinopathy Eval *Check carrier status for certain abnormal hemoglobin disorders to determine risk to the baby and possible treatment for mother*	X		
Tay-Sachs *Check carrier status for certain genetic diseases to determine risk of having a baby with such a disease. Only performed if criteria met*	X		
Mother's Health			
Thyroid Stimulating Hormone (TSH) *As a screen or in women with known thyroid conditions, to adjust medication if necessary*	X		
Blood Glucose *Check for gestational diabetes - early screening only if BMI > 30*	X	X	

I am aware these are the recommended laboratory tests for pregnancy and am also aware if my insurance applies these labs to my deductible, I will be billed by the laboratory for payment.

Patient Signature _____ Date _____