LOWCOUNTRY WOMEN'S
SPECIALISTS
9291 Medical Plaza Drive | N. Charleston, SC 29406 | 843-797-3664

PRENATAL LABORATORY AUTHORIZATION

I authorize the performance of the following prenatal blood screening tests that are considered necessary for the medical management of my pregnancy:

HIV	RUBELLA
HEPATITIS B	SYPHILIS
BLOOD TYPING	COMPLETE BLOOD COUNT

With the discretion of my physician, a drug screen may be performed at any time.

I also understand that I may receive a separate statement from the laboratory performing the above tests.

Date_____ Signature_____

PRENATAL / GENETIC SCREENING QUESTIONNAIRE

In order to give you the best prenatal and / or genetic care and advice, please fill out the following questionnaire. These questions about family health apply to members in both your family and in the baby's father's family. If you do not understand some of the questions, please mark them and ask the nurse / doctor when they interview you.

1. How old will you be when your baby is born? _____

Please circle YES or NO to the following questions:

2. Do you or the baby's father have any close relative descended from Jewish people who lived in Eastern Europe (Ashkenazic Jews)? YES NO
3. If patient or her spouse are black:
   Do you or the baby's father, or any close relative have sickle cell trait or sickle cell disease? If Yes, who _____ YES NO
4. If patient or her spouse are of Italian or Greek (Mediterranean) ancestry:
   Do you or the baby's father, or any close relative have Cooley's anemia or Beta Thalassemia? If Yes, who _____ YES NO
5. In either family, has any doctor told you there is a genetic, chromosomal, or inherited problem? YES NO
6. Does anyone in the family have spina bifida (open spine), hydrocephalus ("water head"), or anencephaly (part of the brain did not develop)? YES NO
7. Does anyone have problems with their muscles, such as muscle weakness, muscular dystrophy, or Duchenne's muscular dystrophy? YES NO
8. Does anyone have Downs Syndrome (mongoloid)? YES NO
9. Is there any close relative who is mentally retarded? YES NO
10. Is there anyone with a bleeding problem - a free bleeder or hemophiliac? YES NO
11. Has any female relative had an amniocentesis? YES NO
12. Has any female relative had three or more miscarriages? YES NO
13. Is there any other family health problems that you are worried your baby might have? YES NO
14. FIRST day of last menstrual period. _____

_____ _____

Nurse / Physician Signature Patient's Signature (Date)