CEDARS-SINAI MEDICAL CENTER®

Prenatal Diagnosis Center

Request for Appointment (Genetic Counseling, Amniocentesis, CVS, Consultation)

Today's Date: ________________

Mother of Baby

Name (Last, First):

Address: City: State:

Home Phone: ( ) Work: ( ) Cell: ( )

E-mail Address: Age at Due Date: Date of Birth: / /

Different Name(s): Social Security #:

☐ Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Asian ☐ Mid-Eastern ☐ Other

Have you ever been a patient at Cedars-Sinai Medical Center or the Prenatal Diagnosis Center? ☐ Yes ☐ No

Blood Type: Antibody Screening: ☐ Positive ☐ Negative MCV:

Vaginal cultures done? ☐ Yes ☐ No

Father of Baby

Name (Last, First):

Age at Due Date: Date of Birth: / /

Different Name(s): Social Security #:

☐ Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Asian ☐ Mid-Eastern ☐ Other

Have you ever been a patient at Cedars-Sinai Medical Center or the Prenatal Diagnosis Center? ☐ Yes ☐ No

Blood Type: Antibody Screening: ☐ Positive ☐ Negative MCV:

OB/Gyn Physician

OB/Gyn Physician's Name:

Address: City: State:

Phone: ( ) Fax: ( )

Infertility Physician

Infertility Physician's Name:

Address: City: State:

Phone: ( ) Fax: ( )

Referral

Which Physician Referred You:

Reason for Referral:

If Jewish or French Canadian, have either you or your partner been screened for Tay-Sachs? (Y) (N)

Type of Appointment Required: Preferred Date: Time: (a.m.) (p.m.)

Pregnancy Data

First Day of Last Menstrual Period: Due Date:

Multiple Pregnancy: (Y) (N) If Yes, #:

☐ Natural Pregnancy ☐ IVF ☐ GIFT ☐ Artificial Insemination ☐ Surrogate

Total Number of Pregnancies: # of Deliveries: # of Miscarriages:

# of Elective Abortions: # of Stillbirths: # of Living Children:

Height: Weight: Allergies: Smoker: (Y) (N)

Medications During Pregnancy:

Family History

Is there anyone in your family or your partner's with mental retardation, birth defects, or genetic disease? (Y) (N)

If yes, please explain:

Insurance

Insurance Company Name: Type: ☐ PPO ☐ HMO ☐ POS ☐ EPO ☐ CASH

Address: Phone: ( )

Member I.D. #: Group #:

Name of Person Insured: Authorization # (if HMO):