OB/GYN SPECIALTY GROUP

Partners for a Lifetime of health

CONSENT FOR CYSTIC FIBROSIS SCREENING

What is cystic fibrosis carrier screening?

Inherited, or genetic, diseases like cystic fibrosis (CF) are passed from parents to their children. This often occurs even when neither parent has the disease. For a child to inherit cystic fibrosis, both parents must have an altered gene that causes CF; that is, both parents must be carriers of an altered CF gene.

Cystic fibrosis carrier screening tells you what your chance, or risk, is for carrying an altered CF gene. Carrier screening can also tell you what your chance is of having a child with CF. Carrier screening cannot, however, tell you if your child will have CF; additional testing is needed for that.

CF carrier screening is performed on a small sample of your blood. During the test, the laboratory will find out if you carry one of the more common changes to the CF gene. Your doctor will provide the lab with information about your race, ethnicity, and any personal or family history of CF to help with interpretation of the results.

This test is not time-sensitive and can be performed at any time during your pregnancy. The cystic fibrosis test is billed separately and most insurance companies do not cover the cost of this test (such as Blue Cross/Blue Shield). Therefore, if you wish to have this test performed, you may be responsible for the cost. This may be requested at the time of the blood draw. The cost is about $150. Medicaid does cover the cost of this test. Since the test is not time-sensitive, we recommend you contact your insurance company to find out if this test is a covered benefit for you before proceeding.

This is an elective test offered during pregnancy.

I have read and understand the information on this form and other information provided by my physician.

Please CHECK ONE: I do _____ do not_____ consent to the performance of the CF screening.

Patient name_____
(Please Print)

_____/_____
Patient Signature Date

_____/_____
Patient Signature Date

OB/GYN Specialty Group
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Acknowledgement of Counseling

My health care provider has discussed with me the effects of:

- Alcohol (Beer, Wine, Wine Coolers, Liquor)
- Tobacco (including second hand smoke)
- Prescriptions Medications (without doctor advice)
- Over the Counter Medications (without doctor or pharmacist advice)
- Other Drugs (street) such as: crack/cocaine, marijuana, barbiturates, amphetamines, etc.
- Contraceptives
- Breastfeeding

on my own health and the health of my unborn child.

LITERATURE GIVEN:

_____ DOH Pamphlet _____Tobacco _____Other Drugs
_____Alcohol _____Cocaine

I understand this information and have been given the opportunity to ask questions concerning substance abuse in pregnancy.

I have been given a toll-free number to call if I should need information or assistance with the problem of substance abuse during my pregnancy.

_____/_____
Patient Signature Date

_____/_____
Patient Signature Date

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MATERNAL BLOOD SCREENING

While most babies are born healthy, there is always a small chance to have a child with a birth defect. A simple blood test during pregnancy can detect two common birth defects, Neural Tube Defect and Down Syndrome.

About 1 in every 1000 babies is born with a Neural Tube Defect. Spina Bifida (open spine) and Anencephaly (open skull) occur when the neural tube, the structure that forms the brain and spine, does not completely develop early in fetal life. The degree of the handicap depends on where the opening is and how big it is. If you have any questions, ask your nurse or healthcare provider.

Most neural tube defects can be discovered with a blood test. When an open defect is present large amounts of a substance called alpha-fetoprotein (AFP) are usually found in the mother's blood.

About 1 in 800 babies has Down Syndrome. It is the most common cause of mental retardation. Children with this condition may also have other physical defects and health problems. A low level of AFP may be present if a fetus has Down Syndrome.

This testing requires one or more blood samples at specific weeks of pregnancy.

IMPORTANT POINTS TO REMEMBER

1. An abnormal test DOES NOT mean your baby has a birth defect, but DOES mean that further testing is recommended.
2. Further testing which may be recommended:
    a. Another blood test.
    b. An ultrasound scan.
    c. Amniocentesis which involves taking fluid from the sac surrounding the fetus space.
3. Decisions about management of the pregnancy, when there is an abnormality, will be yours.
4. The MSAFP test will not look for all types of birth defects. It can find more than 80% of fetuses with open neural tube defect and 75-80% of fetuses with Down Syndrome. There is a 5-6% false positive rate.

I, _____, have read this form and other information provided by my doctor, and have had any questions answered.

CHECK ONE : I do _____ do not _____ choose to have maternal blood screening.

_____/_____

Patient Signature Date

_____/_____

Patient Signature Date

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NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a lifetime of health

HIPAA

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: **treatment, payment, and healthcare operations.** I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time and that I may contact NMHC at any time to receive a current copy.

Patient/Guardian Signature_____**Date**_____/_____/_____

INSURANCE/TX AUTH

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing, and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Authorized Person's Signature_____**Date**_____/_____/_____