COLUMBIA UNIVERSITY
MEDICAL CENTER

Reproductive Genetic Services
Division of Maternal Fetal Medicine
Department of Obstetrics & Gynecology
www.columbiaobgyn.org

Thank you for choosing Reproductive Genetic Services, Division of Maternal Fetal Medicine.

In order to complete the process for your appointment, please fill out the genetic counseling questionnaire (page 2) and bring it to your visit. In addition, please bring your insurance card and driver's license as we will need to make copies for billing purposes.

If you are not a patient of a Columbia OB/GYN or MFM physician, we ask that you also fill out the registration form (page 3) and ensure the following records are faxed to our office at least 3 days prior to your appointment. Our fax # is: 212-326-8784.

- Blood type and Rh factor (CVS and amniocentesis cannot be performed without this information)
- RBC antibody screen (also called "COOMBS")
  - This screen must be drawn during current pregnancy
- CBC (complete blood count)
- Gonorrhea culture
- Most recent ultrasound
- If the following lab work has been performed we also request it be sent, but is not required for procedure:
  - Any genetic screening that has been performed on you/your partner in this or a previous pregnancy (i.e. cystic fibrosis, fragile X, universal carrier screening, etc…)
  - Hemoglobin electrophoresis

Your appointment will be at one of the following locations:

Columbia Midtown
51 W. 51st Street
Suite 320, 3rd Floor
New York, NY 10019

Morgan Stanley Children's Hospital
3959 Broadway (between 165th & 166th)
CHONY Central, 12th Floor
New York, NY 10032

Please remember that if you have a bleeding or clotting disorder and are on heparin, fragmin (low weight heparin) or any other anticoagulation therapy other than aspirin, our office must be notified prior to your visit.

Please call us at 212-305-2138 if you need to cancel/reschedule your appointment.

For patients who are scheduled for genetic consultation and procedure, you should expect to be at our office for approximately 2-3 hours. We ask that you refrain from bringing children to the Columbia Midtown location. If your appointment is at 3959, children are not allowed in the waiting are or office; we apologize for this inconvenience.

We look forward to meeting you!

COLUMBIA UNIVERSITY MEDICAL CENTER

GENETIC COUNSELING QUESTIONNAIRE

Referring MD: _____ Tele: _____

Name of Patient: _____ DOB: _____ Age: _____

Reason for Visit: _____

Street Address: _____ City/State: _____ Zip Code: _____

Tele: H _____ W _____ C _____

Ethnic Background: _____ Profession: _____

Name of Spouse: _____ DOB: _____ Age: _____

Ethnic Background: _____ Profession: _____

Are you currently pregnant? _____ What is your due date? _____

When was the first day of your last menstrual period? _____

Did you seek the assistance of fertility specialists for your current pregnancy? _____

How many times have you been pregnant in total? _____

Have you had any miscarriages, stillbirths or a baby that died in infancy? _____

Did you take any medications during this pregnancy? _____ If yes, what are the names of the medications:
_____

Did you drink any alcoholic beverages during this pregnancy? _____

Are you a smoker or non-smoker? _____

Do you or your partner have any chronic health problems, such as: diabetes, high blood pressure, ect?
_____

Have you or your partner had a child with abnormality or birth defect? _____

Have you ever undergone prenatal diagnosis through CVS or Amniocentesis in the past? _____

Do you, your partner, or any members of your families have any of the following:

☐ Birth Defect
☐ Spinal Bifida
☐ Muscular dystrophy
☐ Hearing Loss
☐ Kidney Disease
☐ Seizures
☐ Bleeding Problems
☐ Cleft Lip/Palate
☐ Anemia (Sickle Cell/Thalassemia)
☐ Mental Retardation
☐ Blindness
☐ Other Genetic Problem: _____

PATIENT REGISTRATION

Last Name _____ First Name _____ MI _____

Address _____City/State _____ Zip Code _____ Apt. # ____

Telephone – Home _____Cell _____Work _____

Email Address _____DOB ___/___/___ SS # _____

Father's 1st Name _____ Mother's 1st Name _____Marital Status _____

Employer Name & Address _____

Pharmacy Name & Phone _____ PCP Name & Phone _____

INSURANCE INFORMATION

1. Insurance Name _____
2.

Insurance ID _____ Group # _____

Subscriber's Name _____ Subscriber's D.O.B. _____

3. Insurance Name _____
4.

Insurance ID _____ Group # _____

Subscriber's Name _____ Subscriber's D.O.B. _____

I, _____ (Please Print) authorize the Department of Maternal Fetal Medicine to release any medical information required to properly adjudicate my health insurance claim(s). I also understand that my referring physician, which I have listed below will be provided with a copy of any reports generated as a result of the requested diagnostic test and/or procedures.

Referring Physician Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize the release of information necessary to process any claims.

Patient (or Responsible Party) Signature _____ Date_____