# NEW MATERNITY FORM

NAME:_____DATE_____

MOTHER:

Will you be 35 years or older at the time of the birth? YES_____NO_____

Your race_____

Have you received any X-Rays, CT scans, or MRI's during this pregnancy? List dates and

Names of Tests_____

_____

BOTH PARENTS:

Are you of Jewish decent?_____

ROUTINE BLOODWORK:

At your first prenatal visit, we will be giving you a lab slip to have routine bloodwork drawn.

This includes blood type, Rh, antibody screen, rubella status, Hemoglobin, Syphilis screen,

hepatitis B screen, HIV screen, and a urine culture. Other lab tests may be added depending on

your medical history. We will have you sign a consent Form for HIV screening.

IF YOU DO NOT WANT TO BE TESTED FOR HIV PLEASE SIGN HERE_____

CYSTIC FIBROSIS TESTING (C.F.)

Cystic Fibrosis is an inherited disease that may be passed down to unborn children when

Both parents carry the gene. It affects the lungs and digestive tract and is a lifelong illness

Currently has no cure. There is a blood test that can detect 90% of the C.F. mutations

That may elect to have done. It may not be covered by your insurance.

DO YOU WANT TO BE TESTED? YES_____NO_____