Appendix D – Prenatal Genetic Risk Assessment Form (to be completed by medical staff)

Patient's name: _____ Date: _____

1. Are you or the baby's father of the following ethnic backgrounds?
   a. Jewish (Eastern European or Mediterranean background) or French Canadian? ❑ Y ❑ N
      If yes, have you ever been tested for Tay-Sachs? ❑ Y ❑ N
   b. Italian, Greek or Mediterranean? ❑ Y ❑ N
      If yes, have you ever been tested for beta-thalassemia? ❑ Y ❑ N
   c. Southeast Asian or Philippine? ❑ Y ❑ N
      If yes, have you ever been tested for alpha-/beta-thalassemia? ❑ Y ❑ N
   d. African American? ❑ Y ❑ N
      If yes, have you ever been tested for sickle cell trait? ❑ Y ❑ N
   e. Have you ever been tested for cystic fibrosis? ❑ Y ❑ N
2. Will you be 35 years old or older when your baby is born? ❑ Y ❑ N
   Will the baby's father be 50 or older when the baby is born? ❑ Y ❑ N
3. Have you had three or more unplanned pregnancy losses? ❑ Y ❑ N
4. Have you used any street drugs (including marijuana and cocaine) or chemicals in the past six months or during this pregnancy? ❑ Y ❑ N
5. If any close relatives have these hereditary medical problems, check "Y"; check "N" if a condition does not apply. For the following questions, "close" relatives are considered to include the grandparents, parents, aunts, uncles, first cousins, brothers, sisters, or children of yours or the baby's father.
   a. Child with a known birth defect* or stillborn (* e.g., heart defect, cleft lip/palate, club foot) ❑ Y ❑ N
   b. Chromosome abnormalities (e.g., Down syndrome, Turner syndrome, Klinefelter syndrome) ❑ Y ❑ N
   c. Abnormalities of the brain or spinal column (e.g., hydrocephalus, spina bifida, meningomyelocele, microcephalus, mental retardation) ❑ Y ❑ N
   d. Abnormalities of the bones or skeleton (e.g., osteogenesis imperfecta, achondroplasia, limb deformities, dwarfism) ❑ Y ❑ N
   e. Inherited disorders of the blood (e.g., hemophilia, sickle cell trait or disease, thalessemia) ❑ Y ❑ N
   f. Neuromuscular disorders (e.g., muscular dystrophy, myotonic dystrophy) ❑ Y ❑ N
   g. Metabolic or chemical disorders (e.g., Tay-Sachs disease, cystic fibrosis, glycogen storage diseases, Hurler's and Hunter's syndromes) ❑ Y ❑ N
   h. Skin disorders (e.g., neurofibromatosis, ichthyosis, tuberous sclerosis) ❑ Y ❑ N
   i. Hereditary visual or hearing defects ❑ Y ❑ N
   j. Unusual reactions to anesthetic agents ❑ Y ❑ N
   k. Other inherited genetic diseases not listed above (e.g., Huntington's chorea, polycystic kidney disease, congenital adrenal hyperplasia) ❑ Y ❑ N
6. Do you have any serious health problems such as diabetes or epilepsy? ❑ Y ❑ N
7. Were you ever on a special diet as a child or do you know of a family member with PKU (phenylketonuria)? ❑ Y ❑ N
8. Do you or the father of the baby have a family history of psychiatric disease or mood disorders (e.g., manic depression, depression, anxiety disorder, schizophrenia)? ❑ Y ❑ N
9. Do you or the father of the baby have any concerns about conditions that may be inherited? ❑ Y ❑ N

Patient's Signature: _____ Date: _____

[ ] No known increased risk.
[ ] Positives reviewed; formal counseling not indicated.
[ ] Genetic counseling and/or amniocentesis have been offered and refused.
[ ] Genetic counseling and/or amniocentesis scheduled and/or referral done.
[ ] Undecided at this time.

Form completed by: _____ (Init.) _____

Return to Table of Contents **BACK** **www.icsi.org**