LADIES FIRST OB/GYN

AUDRY CASTELLANOS-VIDAURRE, M.D., F.A.C.O.G.

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PEMBROKE PINES, FL. 33028

P: 954-435-3220/F: 954-435-3667

I have been furnished information by Audry Castellanos-Vidaurre, M.D., F.A.C.O.G, Benny Esquinazi, M.D., Sylvia Velarde, M.D., Vicente Silva, M.D., Irwin Steinberg, M.D., Alicia Acon, M.D., James Duerkas, M.D, prepared by Florida Birth Related Neurological Injury Compensation Association (NICA), and have been advised that the doctors are participating physicians in the program, wherein certain limited compensation is available in the event of certain neurological injuries occurring during labor, delivery or resuscitation. For specifics on the program, I understand I can contact The Florida Birth Related Neurological Injury Compensation Association (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, and Fl. 32313,-1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

IN THE EVENT OF AN EMERGENCY WHEN DR. CASTELLANOS-VIDAURRE IS ON VACATION, ONE OF THE FOLLOWING PHYSICIANS WILL BE THE "ON-CALL" COVERING PHYSICIAN AS WELL AS ANY OTHER PHYSICIAN WITH PRIVILEGES AT MEMORIAL HOSPITAL WEST:

BENNY ESQUENAZI, M.D.
VICENTE SILVA, M.D.
ALICIA ACON, M.D.

JAMES DUERKAS, M.D.
IRWIN STEINBERG, M.D.
SYLVIA VELARDE, M.D.

DATED THIS _____ DAY OF

_____,

20_____.

_____
PATIENT NAME

_____
SOCIAL SECURITY NUMBER

ATTEST:

_____
PHYSICIAN OR NURSE

_____
PATIENT SIGNATURE

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE MONTH DAY YEAR | AGE | RACE | MARITAL STATUS S M W D SEP

OCCUPATION
☐ HOMEMAKER
☐ OUTSIDE WORK
☐ STUDENT Type of Work

EDUCATION (LAST GRADE COMPLETED)

HUSBAND/FATHER OF BABY: PHONE:

ADDRESS:

ZIP: PHONE: (H) (O)

INSURANCE CARRIER/MEDICAID #

EMERGENCY CONTACT: PHONE:

TOTAL PREG	FULL TERM	PREMATURE	AB, INDUCED	AB, SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) ☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION ☐ FINAL _____

MENSES MONTHLY ☐ YES ☐ NO PRIOR MENSES _____ DATE

FREQUENCY: Q _____ DAYS ON BCP AT CONCEPT. ☐ YES ☐ NO

MENARCHE _____ (AGE ONSET) hCG + ____/____/____

PAST PREGNANCIES (LAST SIX)

DATE MONTH / YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES / NO	COMMENTS / COMPLICATIONS

PAST MEDICAL HISTORY

	O Neg + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE / UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. HEPATITIS / LIVER DISEASE		
9. VARICOSITIES / PHLEBITIS		
10. THYROID DYSFUNCTION		
11. TRAUMA/DOMESTIC VIOLENCE		
12. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	#YEARS USE
13. TOBACCO			
14. ALCOHOL			
15. STREET DRUGS			

	O Neg + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
16. D (Rh) SENSITIZED		
17. PULMONARY (TB, ASTHMA)		
18. ALLERGIES (DRUGS)		
19. BREAST		
20. GYN SURGERY		
21. OPERATIONS / HOSPITALIZATIONS (YEAR & REASON)		
22. ANESTHETIC COMPLICATIONS		
23. HISTORY OF ABNORMAL PAP		
24. UTERINE ANOMALY/DES		
25. INFERTILITY		
26. RELEVANT FAMILY HISTORY		
27. OTHER		

COMMENTS: _____

ACOG ANTEPARTUM RECORD (FORM

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

DRUG ALLERGY:

RELIGIOUS/CULTURAL CONSIDERATIONS _____

ANESTHESIA CONSULT PLANNED ☐ YES ☐ NO

PROBLEMS/PLANS

1.
2.
3.
4.
5.
6.

MEDICATION LIST: Start date Stop date

1.
2.
3.
4.
5.
6.

EDD CONFIRMATION

INITIAL EDD:

LMP ____/____/____ = EDD ____/____/____
INITIAL EXAM ____/____/____ = ____ WKS = EDD ____/____/____
ULTRASOUND ____/____/____ = ____ WKS = EDD ____/____/____
INITIAL EDD ____/____/____ INITIALED BY _____

18–20-WEEK EDD UPDATE:

QUICKENING ____/____/____ +22 WKS = ____/____/____
FUNDAL HT. AT UMBIL. ____/____/____ +20 WKS = ____/____/____
FHT W/FETOSCOPE ____/____/____ +20 WKS = ____/____/____
ULTRASOUND ____/____/____ = ____ WKS = ____/____/____
FINAL EDD ____/____/____ INITIALED BY _____

VISIT DATE ____ (YEAR)	WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPTOMS: +=PRESENT O=ABSENT	CERVIX EXAM (DIL./EFF./STA.)	BLOOD PRESSURE	EDEMA	WEIGHT	URINE (GLUCOSE/ALBUMIN)	NEXT APPOINTMENT	PROVIDER (INITIALS)

COMMENTS:

PROBLEMS: _____

COMMENTS: _____

ACOG ANTEPARTUM RECORD (FORM C)

Patient Addressograph

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS			12. MENTAL RETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV < 80			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			14. MATERNAL METABOLIC DISORDER (EG. INSULIN-DEPENDENT DIABETES, PKU)		
5. DOWN SYNDROME			15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY–SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			16. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			17. MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. HEMOPHILIA			IF YES, AGENT(S):		
9. MUSCULAR DYSTROPHY			18. ANY OTHER		
10. CYSTIC FIBROSIS					
11. HUNTINGTON CHOREA					

COMMENTS/COUNSELING: _____

INFECTION HISTORY

	YES	NO		YES	NO
1. HIGH RISK HEPATITIS B/IMMUNIZED?			4. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS		
3. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. OTHER (SEE COMMENTS)		

COMMENTS: _____

_____ INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE ____/____/____ PREPREGNANCY WEIGHT _____ HEIGHT _____ BP _____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. FUNDI	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. TEETH	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals): _____

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CONSENT FORM FOR FETAL CHROMOSOMAL SCREEN: FIRST AND SECOND TRIMESTER SCREENING

Babies may be affected with chromosome abnormalities, the most common being Down Syndrome, a disorder that leads to mental retardation and other birth defects. Generally, risk of chromosome abnormalities becomes greater as the age of the expectant mother increases. For mothers 35 years of age or more at the time of delivery, the standard recommendation is to offer a genetic amniocentesis, the removal of a sample of the amniotic fluid for analysis.

Because younger mothers can also have an affected baby, a non-invasive screening test using a blood sample is generally offered to those under the age of 35. The test, commonly known as the alpha-fetoprotein(AFP), or multiple marker screen (AFP4), is completed during the second trimester of the pregnancy and detects approximately 60-80% of babies affected with Down Syndrome. It also provides information about the baby's risk of Trisomy 18 (a chromosomal disorder that causes severe mental retardation and birth defects), as well as risk of open neural tube defects(ONTD- occur when the developing baby's spine or skull does not form completely, as in spina bifida).

It is important to understand that a screening test is limited; a result that shows increased risk does not mean that the baby has actually an anomaly; a result that is with in the normal range does not necessarily mean that there are no abnormalities present. Mothers whose test results show increased risk will be offered further evaluation by invasive testing with amniocentesis. A diagnostic test that identifies most known chromosome abnormalities.

Now, more screening options are available to you as an alternative to the single blood sample in the second trimester. Each option has relative advantages and disadvantages. Your options are as follows:

- **FirstScreen (11weeks – 13 weeks and 6 days)**

This screening test, performed in the firs trimester of pregnancy, includes a sonogram to measure the amount of fluid accumulation at the back of the baby's neck (Nuchal Translucency) and a blood sample that is tested for special markers. FirstScreen helps to identify babies at increased risk of having Down Syndrome or Trisomy 18, but does not identify risk for ONTD (spina bifida). If you choose this option, another blood sample should be taken in the second trimester to analyze alpha-fetoprotein for the risk of ONTD. FirstScreen detection rates fro Down Syndrome and Trisomy 18 are lower than IntegratedScreen, but the results are available earlier in the pregnancy.

- **IntegratedScreen**

This screening test combines the measurements obtained in the FirstScreen described above with additional information obtained from another blood test, the alpha-fetoprotein 4 (AFP 4), taken at approximately 16- 18 weeks. The result of this screen will not be available until the second trimester of pregnancy, as the results of the second blood sample are needed to complete the analysis. Of all the currently available screening tests, this screen has the highest detection rates for Down Syndrome and Trisomy 18. IntegratedScreen also reports the risk of Open Neural Tube Defect (ONTD).

- **Serum IntegratedScreen**

This screening test includes first and second trimester blood samples described for the IntegratedScreen. It does not include the sonogram of the baby's neck (Nuchal Translucency). The results of this screen are not available until the second trimester of pregnancy. Like the IntegratedScreen, results include risk of ONTD; but the detection rate for Down Syndrome is slightly lower than that of the Integrated Screen.

- **Multiple Marker Screen (AFP4)**

The multiple marker screen is the standard screening test offered at the present. The Multiple Marker Screen (AFP4), a single blood test obtained at approximately 16-18 weeks, measures levels of alphafetoprotein (AFP) combined with levels of certain other proteins and hormones from the pregnancy. The quadruple marker test (AFP4), the best second trimester prenatal serum screening test currently available, measures levels of a three additional markers: unconjugated estriol (uE3), human chorionic gonadotropin (hCG), and inhibin A. When tests of these markers are added to the AFP test, the combination gives more information about the risk of having a baby with Down syndrome than the AFP test alone. No testing is performed in the first trimester of pregnancy. Detection rates for Down Syndrome and trisomy 18 are lower than with the IntegratedScreen, but detection rates for ONTD are the same.

- No Screening

You may choose not to undergo any screening test. Some patients who feel that they would not intervene id the baby should have a problem may prefer this option.

- Amniocentesis and genetic counseling

This is a diagnostic test and is the standard option for mothers who are 35 years old or more. This is also the recommended option for mothers who have had a previous baby affected with a chromosome anomaly or ONTD.

The screening tests offer the following performance:

SCREEN TYPE	FirstScreen	IntegratedScreen	Serum Integrated Screen	Multiple Marker Screen	No Screen	Amniocentesis
Down Syndrome Detection Rate	83%	92%	87%	81%	None	100%
False Positive Rate	5%	5%	5%	5%	None	Near 0%
Trisomy 18 Detection Rate	80%	90%	90%	80%	None	100%
ONTD Detection Rate	None	80%	80%	80%	None	Near 100%
Risk to the baby	0%	0%	0%	0%	None	0.5% loss

What if your test shows an increased risk?

If your screening test shows and increased risk, it does not mean that a problem has been diagnosed. It only means that your baby should be further evaluated. In that case, you will be offered additional tests which can determine whether the bay has a disorder or if there are other explanations for the test result. If your screening test shows results in the normal range, it does not guarantee that your baby is normal. It means that the risk of a chromosome problem is low. Other problems or abnormalities may be present or may develop in the baby.

CONSENT

My healthcare provider may release my ultrasound, amniocentesis, chorionic villus sampling, and pregnancy outcome information to the laboratory. I understand that there are benefits and limitations for any test, including false positives and false negative results. All my questions have been satisfactorily answered. I understand that this test is voluntary and I may decline testing at any point. I understand that my insurance company may not cover this service and I agree to provide payment.

Your Choices:

- If you are 35 years old or more at the time of delivery, or have had a previous baby with a chromosome anomaly or Open Neural Tube Defect (ONTD):

I choose:

O Genetic counseling and possible amniocentesis (the standard recommendation)

O No testing at all

O One of the screens below

-If you are less than 35 years-old at the time of delivery, and have no had a previous baby with a chromosome anomaly or Open Neural Tube Defect (ONTD):

I choose:

O **FirstScreen** (sonogram for Nuchal Translucency and blood at 11 weeks- 13 weeks and 6 days)

O **IntegratedScreen** (FirstScreen above plus another blood sample at approximately 16-18 weeks)

O **Serum IntegratedScreen** (only the blood samples described for the IntegratedScreen, no sonogram for Nuchal Translucency)

O **Multiple Marker Screen** (blood sample at approximately 16-18 weeks for AFP4)

O No screen at all

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Witness

Disease	Cystic Fibrosis (CF)	Spinal Muscular Atrophy (SMA)	Fragile X Syndrome
Symptoms of Disease	The most common inherited disease of children and young adults. CF primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 30's. CF does not affect intelligence.	The most common inherited cause of early childhood death. SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infants in the first months of life and can cause death between 2-4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.	The most common inherited cause of mental retardation. Fragile X syndrome involves developmental delay, mental retardation, autism and hyperactivity. It primarily affects boys. Women who are carriers are at risk to have a child with mental retardation.
Inheritance	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with cystic fibrosis.	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA.	If a mother is a carrier, there is a 50% chance to have a child with fragile X syndrome.
General Population Carrier Frequency	1 in 30 average in the U.S. Varies by ethnicity	Ranges from 1 in 35 to 1 in 117 in the U.S. Varies by ethnicity	~1 in 260 women Occurs in all ethnic backgrounds

Model Informed Consent/Decline for Carrier Testing

You should be certain you understand the following points:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause CF, SMA and/or fragile X syndrome.
- The tests do not detect all carriers of these diseases.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have carrier testing is completely mine.
- No other test will be performed and reported on my sample unless authorized by my doctor, and any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the test results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

For CF:

- If I am a carrier, testing my partner will help me learn more about the chance that our baby could have CF.
- If one parent is a carrier and the other is not, it is still possible that the baby will have CF, but the chance is less than 1%.
- If both parents are carriers, prenatal testing is available to find out whether or not the baby has inherited the abnormal CF genes.

For SMA:

- If I am a carrier, testing my partner will help me learn more about the chance that our baby could have SMA.
- If one parent is a carrier and the other is not, it is still possible that the baby will have SMA, but the chance is less than 1%.
- If both parents are carriers, prenatal testing is available to find out whether or not the baby has inherited the abnormal SMA genes.

For Fragile X:

- If I am a carrier, prenatal testing is available to find out whether or not the baby has inherited the abnormal fragile X gene.

I have read, or had read to me, the information in this brochure and I understand it. Before signing this form, I have had the opportunity to discuss carrier testing further with my doctor, someone my doctor has designated, or with a genetics professional. I have all the information I want, and all my questions have been answered. I have decided that:

☐ I want CF carrier testing. ☐ I do not want CF carrier testing. Patient Signature: Date:	☐ I want SMA carrier testing. ☐ I do not want SMA carrier testing. Patient Signature: Date:	☐ I want fragile X carrier testing. ☐ I do not want fragile X carrier testing. Patient Signature: Date:

About Genzyme Genetics

Genzyme Genetics has been a leader in genetic testing and counseling services for over 25 years.
This brochure is provided by Genzyme Genetics as an educational service for physicians and their patients.

For more information on our genetic testing and counseling services, please visit our web sites: www.mytestingoptions.com and www.genzymegenetics.com.

genzyme

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AFP-PLUS

AFP-Plus is maternal serum (blood) screen for birth defects. The AFP-Plus testing incorporates the features of AFP screening but detects three times as many cases of Downs Syndrome as AFP testing alone.

AFP-Plus is a combination of four maternal serum (blood) tests; alpha fetoprotein (AFP), inhibin A., unconjugated estriol (uEST), and human chronic gonadotropin (HCG). The AFP-Plus screening procedure is based on studies showing that pregnancies affected with Down's Syndrome have lower serum levels of AFP and uEST and higher levels of HCG than women with unaffected pregnancies.

AFP-Plus testing detects approximately 85% of open neural tube defects and approximately 60-70% of Down's Syndrome pregnancies. AFP-Plus does not reliably screen for other chromosomal abnormalities.

AFP-Plus is a screening test. Normal results DOES NOT guarantee a normal baby. Should the AFP-Plus results be abnormal, additional diagnostic tests or procedures may be recommended.

I have read the above and understand the benefits of AFP-Plus screening.

I request the following testing:

☐ AFP-Plus

☐ I decline any testing

(PATIENT NAME) _____ (SIGNATURE) _____

(DATE) _____ (WITNESS) _____

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HIV TEST IN PREGNANCY – CONSENT FORM

INFORMATION IS PROVIDED IN ACCORDANCE WITH FLORIDA LAW

HIV/AIDS is an important health concern for a pregnant woman because she can pass the HIV virus to her baby during pregnancy or childbirth or through breastfeeding. HIV testing is recommended as a routine test for all pregnant women. It is much better for a woman to know her HIV status as early in pregnancy as possible so she can make important decisions about health care and breastfeeding. Tests are available to detect antibodies for HIV that are safe and can be done along with other prenatal blood test.

A positive test does not necessarily mean that you have AIDS or that you will become ill with AIDS. A positive test does mean that you can infect others with the virus and that you must take precautions to prevent spreading the infection. If your test is positive, you will gain knowledge and understanding of an important medical condition and be able to inform your sexual partner(s) and health care provider(s).

There are medications that are available that can help reduce the chances of a pregnant woman who has HIV from passing the virus to her baby. If a pregnant woman is HIV positive and does not get treatment, her baby has about a 25% chance of getting HIV from her. If an HIV positive pregnant woman receives appropriate medication, as late as during the delivery of her child, she can reduce the risk of transmission by at least 50%.

A negative test result means that you have not been infected with HIV-1, HIV-2. If you have been engaging in behaviors that put you at risk, you may want to be retested in approximately six (6) months. A negative test may also mean that your body has not had time to develop antibodies to HIV-1, HIV-2 and that you have an early infection.

Because treatment is so effective in preventing babies from getting HIV, Florida Law and regulations require that every pregnant woman be counseled about HIV and the benefits of testing and be offered and HIV test along with the standard blood test for syphilis and hepatitis B surface antigen (HBsAg). Testing must be offered at the time of the first examination relating to the current pregnancy and again at 28 to 32 weeks of gestation.

Although HIV testing is routinely performed as a part of the antenatal testing protocol, you have the right to refuse the test. The decision to have testing for syphilis, hepatitis B or HIV is voluntary and you may withdraw your consent at any time.

Your physician will answer any questions you may have about HIV testing. If you are pregnant and you test positive for HIV, your physician can provide the care you need and information about services and options available to you. Your physician can tell you about the risks of passing the HIV virus to your baby, medications given during pregnancy that can significantly reduce the risk of passing the virus to your baby, and the medical care available for babies who may be infected with HIV.

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CONSENT TO HIV1/2 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the results have been explained to me. I understand that if the results indicate that my blood contains antibodies to HIV, it means that I may have been infected with the HIV virus, which is believed to cause AIDS (Acquired Immune Deficiency Syndrome).

AT FIRST PRENATAL VISIT

☐ I authorize my healthcare providers to collect one or more blood specimens from me at the time of my first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV-1/2. This is the virus that has been associated with AIDS. I understand that my physician will report the test results to me in person and not over the phone or by mail. At that time, I will have the opportunity to receive counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of exposure to and transmission of HIV has been made available to me.

☐ **REFUSAL OF HIV1/2 ANTIBODY TESTING**
With the information presented above having been explained to me completely and clearly in the language I understand, all my questions having been answered with full knowledge of the consequences, I refuse to give consent for HIV testing.

CONSENT TO RELEASE

I understand that the test results will be confidential and will not be disclosed to any person without my consent unless permitted or required by law. I hereby consent to the release of the test results to Ladies first OB/GYN. I understand Ladies First OB/GYN will comply strictly with the law regarding access by its employees to the test results. I also consent to the release of the test results to _____.

_____ _____
(Name of Patient) (Signature)

_____ _____
(Witness) (Date)

IN THIRD TRIMESTER

☐ I authorize my healthcare provider to repeat the testing for sexually transmitted disease and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy.

☐ I decline repeat HIV testing in the third trimester of pregnancy. I decline repeat testing for sexually transmitted disease and HIV later in pregnancy.

_____ _____
(NAME OF PATIENT) (SIGNATURE)

_____ _____
(WITNESS) (DATE)

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CORD BLOOD COLLECTION

Cord blood stem cells are used in a variety of medical treatments and have the power to change lives-and save lives. By saving your baby's cord blood, you can secure an invaluable medical resource that can protect your baby and family today and into the future.

We will gladly work with the company of your choosing if you decide to participate in cord blood collection. The cost for this service is $250, and payment will be due prior to the collection of your cord blood.

My signature below acknowledges that I am aware of the fee for cord blood collection.

PATIENT NAME

PATIENT SIGNATURE / DATE

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OB CARE & DELIVERY COVERED/NON-COVERED SERVICE ACKNOWLEDGEMENT

YOUR FEE INCLUDES THE FOLLOWING:

- 9 months of obstetrical care and delivery
- Routine office visits
- Urinalysis for each prenatal office visit
- Phone calls related to any medical problem
- Hospital care when in labor
- Doctor on-call 24 hours a day
- Stitches or staple removal
- 4-6 week post-partum visit

YOUR FEE DOES NOT INCLUDE:

- Ultrasounds
- Non-stress tests
- Emergency room care or hospitalizations for anything other than labor
- Any laboratory work
- Emergency room care for complications that arise during pregnancy
- Circumcision
- Any other type of surgery whether elective or medically indicated
- Hospital fees
- Emergencies during office hours

I UNDERSTAND THE ABOVE AND ACKNOWLEDGE RECIEPT OF A COPY.

(SIGNATURE) _____ (DATE) _____

Broward Healthy Start Coalition, Inc.

Together, supporting mothers and babies

CONGRATULATIONS on YOUR Pregnancy!

Please take a moment to complete the attached Healthy Start Form [the one marked "Florida's Healthy Start Prenatal Risk Screening Instrument"]

Healthy Start is NOT:

- a welfare program
- just for Medicaid recipients
- a government agency

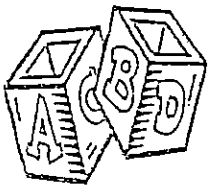
Healthy Start IS:

- a private, non-profit organization
- a community based resource that provides FREE services to families, such as:
  - **Childbirth Support and Education**
  - **Parenting Support and Education**
  - **Breastfeeding Support and Education**
  - **Nutritional Support and Education**
  - **Other supportive services**

But we Can't Do IT if you don't Say "YES" and SIGN the FORM!!!

Just say "YES" to the best possible start for your baby

a Healthy Start!!!



MEDICATION LIST FOR OB PATIENTS

Upper Respiratory Colds:

- NO Advil
- NO Nyquil
- Tylenol, 1-2 tablets every 4-6 hours
- Saline Nasal Sprays for Congestion – Ocean Air
- Robitussin DM or Triaminic, 2 teaspoons every 4-6 hours for cough
- Gargle with warm salt water
- Lozenges for cough or sore throat
- Vicks or other Menthol Ointments
- Vaporizers, hot showers, or humidifiers for congestion
- Warm, moist compress on the face for sinus pain
- Plenty of fluids

Morning Sickness:

- Acupressure point wristbands
- Vitamin B6, 25mg 3-4 times a day
- Ginger Ale
- Papaya chewable tablets
- Dry crackers
- Emetrol or Emecheck (over the counter)
- Unisom 12.5mg (1/2 tablet) 3-4 times a day

Constipation

- 8-10 glasses of water a day
- Fruits and vegetables
- Bran
- Warm fluids
- Prune juice
- Metamucil, one rounded teaspoon in 8oz. of fluid for 2-3 days

Hemmoroids

- Tucks
- Metamucil
- Bran
- Pericolace stool softner
- Annusol

Heartburn:

- Maalox
- Tums
- Mylanta
- Pepcid AC

Diarrhea:

- Lomotil
- Kaopectate
- Immodium

All of the above mentioned medications are safe to take in pregnancy

Ladies First OB/GYN LLC
Audry Castellanos-Vidaurre, M.D., F.A.C.O.G.
601 North Flamingo Road Suite 311
Pembroke Pines, FL 33028
954-435-3220-PHONE
954-435-3667-FAX

CORD BLOOD COLLECTION

There will be a **$250.00** charge for the physician's fee for performing the cord blood collection at time of delivery. (example: Viacord, Cord Use, etc.) This is required to be paid prior to delivery.

CIRCUMCISIONS

The fee for a circumcision is **$425.00**. This is a *NON COVERED SERVICE* if you have Medicaid. In the event that you give birth to a male child; this balance must be paid prior to your delivery date in order for the service to be performed

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FMLA FORMS

All **FMLA** forms and paper work must be brought in to the office on ***your 28th week visit***. As a reminder this would be the visit when you would be having your glucose test.

It will take our staff *5 to 10 business days* to complete the forms.

All **FMLA** forms will be returned to patient, they will NOT be faxed to employer.

THANK YOU FOR YOUR COOPERATION

LADIES FIRST OB/GYN

AUDRY CASTELLANOS-VIDAURRE, M.D., F.A.C.O.G.

601 N FLAMINGO ROAD SUITE 311

PEMBROKE PINES, FL. 33028

P: 954-435-3220/F: 954-435-3667

Dear OB Patient,

This letter is to inform you of the steps you should take in the event of an emergency after regular office hours.

1. Call the office number 954-435-3220.
2. Once the recording starts press "0" to speak with an operator.
3. Give the operator your full name, date of birth, and callback number.
4. Tell the operator this is an **EMERGENCY CALL.**
5. If you do not receive a call from the physician within **15 minutes**, **CALL THE OFFICE AGAIN!**

There is always a doctor on call to assist you after hours.

Sincerely,

Dr. Audry Castellanos-Vidaurre