Patient Addressograph

DATE ______________________

NAME ____
LAST FIRST MIDDLE

ID # ________________ HOSPITAL OF DELIVERY ________________

NEWBORN'S PHYSICIAN ________________ REFERRED BY ________________

PRIMARY PROVIDER/GROUP ________________

FINAL EDD ________________

ADDRESS ________________

BIRTH DATE MONTH DAY YEAR	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS		
OCCUPATION		EDUCATION (LAST GRADE COMPLETED)		ZIP	PHONE (H)	(O)
LANGUAGE		ETHNICITY		INSURANCE CARRIER/MEDICAID #		
HUSBAND/DOMESTIC PARTNER		PHONE		POLICY #		
FATHER OF BABY		PHONE		EMERGENCY CONTACT	PHONE	

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

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _______ DAYS MENARCHE __________ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES _______ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ____/____/____
☐ FINAL _______

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

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. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

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

COMMENTS ____

____

Version 6 Copyright © 2007 The American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920 AA128 345/1098

ACOG ANTEPARTUM RECORD (FORM A)

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 OR OLDER AS OF ESTIMATED DATE OF DELIVERY			13. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			14. MENTAL RETARDATION/AUTISM		
			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
			16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
4. CONGENITAL HEART DEFECT			17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
5. DOWN SYNDROME					
6. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)			19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)					
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS					
11. MUSCULAR DYSTROPHY			20. ANY OTHER		
12. CYSTIC FIBROSIS					

COMMENTS/COUNSELING ______________________________

____

INFECTION HISTORY	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HEPATITIS B, C YES ☐ NO ☐
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			6. OTHER (SEE COMMENTS)

COMMENTS ______________________________

______________________________ **INTERVIEWER'S SIGNATURE** ______________

INITIAL PHYSICAL EXAMINATION

DATE ____/____/____ WEIGHT ______ HEIGHT ______ BMI ______ 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) ______________________________

____

______________________________ **EXAM BY** ______________

Patient Registration Form

Date of Appointment: ____________

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth	Social Security Number	
Patient's Address		City	State	Zip
Home Phone		Mobile Phone	Email Address	
Referred by		Primary Care Physician	Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer/School		
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	Zip
Insured's Social Security Number	Insured's Birthdate			

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Notice of HIPPA practices acknowledgment: I have read and understand the Notice of Privacy Practices.

I Herby authorize Dr. Achille to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. I also authorize Dr. Achille or Staff to obtain medical records from other facilities or Physicians for my continued medical care. This may include but is not limited to the following reports; Pap smear, pathology, pelvic sonograms, breast imaging, Obstetrical imaging specialist reports, and laboratory results that may include H.I.V. results & diagnosis. This release is valid for 1 year from signature.

______________________________ ______________

Signature of Patient or Authorized Guardian   Date

Check-In by

Fabienne Achille, MD., F.A.C.O.G

PATIENT REGISTRATION

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE
We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s)listed below until you notify us otherwise in writing.

1.______________________________ 2.______________________________

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

RELEASE OF MEDICAL RECORDS
If you wish to release your records to yourself, another physician, or someone else, **you must sign a release**. We will process the request and most requests are handled within ten (10) business days. (fees may apply… see the release of records form for more information.

BY INITIALING AND SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THAT:

INSURANCE AUTHORIZATION, RELEASE, AND ASSIGNMENT OF BENEFITS
I hereby authorize Dr.Achille to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Dr. Achille on the behalf of myself and/ or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges that occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, insurance, and any other health/medical plan to issue payment directly to Dr. Achille for medical service rendered to myself and/ or my dependent regardless of my insurance benefits, if any.

I UNDERSTAND THAT NOT ALL SERVICES ARE COVERED BENEFITS AND I AM RESPONSIBLE FOR ANY AMOUNT NOT PAID, REGARDLESS OF INSURANCE POLICY.
INITIALS__________

I have not elected to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, I agree to satisfy and adverse judgments up to the minimum amounts pursuant to s-458.320 (5) (g). Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant
to Florida law.

INITALS__________

- It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current accordingly, all self-pay or insurance co-payments, co-insurance, and deductibles will be collected **at the time of services. Payable by: cash, check, Visa, MasterCard, and Discover.**
- If you do not have payment(s), your appointment may be rescheduled.
- A returned check will result in a $35 service charge **and** all future payment being required in the form of CASH or CREDIT CARD
- **The first request for completion of paperwork is FREE and all others after the fact will cost a $10 FEE FOR EACH FORM (ex: Disability, FMLA, etc…)**

INITALS__________

- If unable to keep your appointment, please notify us **24 hours** in advance so that we may offer that time to another patient. A pattern of repetitive **"no show" or late cancelations may regretfully result in an assessment of a cancelation/no show fee of $50 for each incident.**
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have the referral faxed to our office prior to your appointment.

I have read and understood the above Financial Policy and agree to meet all financial obligation

______________________________ ______________________________
Signature (Patient's Parent/Guardian, if a minor) **Date**

Name ______ Gender ______ Age ______

Date of Appointment: ______

Reason for Visit

What brings you to the office today?

______

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:

______

Current Medications

What medications are you currently taking?

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

Name ______ Dosage ______ Frequency ______

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates(Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name ______ Reaction ______

Name ______ Reaction ______

Past Medical History

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ AIDS / HIV
☐ Back Problems
☐ Bleeding Disorder
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Depression
☐ Ear Problems
☐ Eating Disorder
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Heart Problems
☐ Hepatitis - A, B, or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Joint Disorder
☐ Kidney Disorder
☐ Liver Disorder
☐ Lung Disease
☐ Measles
☐ Migraines
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Stroke
☐ Skin Disorder
☐ Stomach Ulcer
☐ Substance Abuse
☐ Thyroid Disorder
☐ Tuberculosis
☐ Venereal Disease

Hospitalizations & Surgeries

Reason ______ Date ______

Reason ______ Date ______

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism
☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ AIDS/HIV
☐ Bleeding Disorder
☐ Blood Disorder
☐ Cancer
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Genetic Disorder
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Joint Disorder
☐ Kidney Disease
☐ Liver Disorder
☐ Lung Disease
☐ Migraines
☐ Psychiatric Disorders
☐ Osteoporosis
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder

Details: ______

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year ______

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years ______ # packs/day ______

Do you smoke now?

☐ Yes ☐ No # packs/day ______

Do you use recreational drugs?

☐ Yes ☐ No types? ______ # times/week ______

How much alcohol do you drink per week?

drinks/week ______

How much caffeine do you drink per day?

drinks/day ______

How often do you exercise?

times/week ______

Check-In by

Name ______ Gender ______ Age ______

Date of Appointment: ______

OBGYN History

Have you ever had or do you currently have any of the following?

- [ ] Abnormal Vaginal Bleeding
- [ ] Abnormal Pap Smear
- [ ] Bleeding between Periods
- [ ] Breast Lump
- [ ] Breast Cancer
- [ ] Breast Surgery
- [ ] Cervical Cancer
- [ ] Chlamydia
- [ ] Colposcopy
- [ ] Cryosurgery
- [ ] DES Exposure
- [ ] Extreme Menstrual Pain
- [ ] Fibroids
- [ ] Genital Warts
- [ ] Gonorrhea
- [ ] Herpes
- [ ] Hot Flashes
- [ ] HPV
- [ ] Infertility
- [ ] Irregular Periods/Bleeding
- [ ] Nipple Discharge
- [ ] Ovarian Cysts
- [ ] Ovarian Cancer
- [ ] Painful Intercourse
- [ ] Pelvic Inflammatory Disease
- [ ] Uterine Cancer
- [ ] Urinary Incontinence
- [ ] Yeast Infections – Frequent

Pregnancy History

Please describe any pregnancies you have had.

______ # of Pregnancies ______ # of Full Term ______ # of Miscarriages ______ # of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

______

______

______

______

Are you currently pregnant?

[ ] Yes [ ] No

Are you trying to become pregnant?

[ ] Yes [ ] No

Do you need birth control or contraceptive advice?

[ ] Yes [ ] No

What method of birth control do you use?

______

Menstrual History

When was the first day of your last period?

______

How often does your period occur?

______

How long does your period last?

______

Is your period regular?

[ ] Yes [ ] No

What age were you when you had your first period?

______

What age were you at menopause?

______

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
[ ] Blood Sugar-Fasting		
[ ] Breast Self Exam		
[ ] Cholesterol Test		
[ ] Colonoscopy		
[ ] CT/CAT Scan		
[ ] Dexascan (Bone Density)		
[ ] EKG		
[ ] Echocardiogram		
[ ] Fecal Occult Blood Test		
[ ] Mammogram		
[ ] MRI		
[ ] Pap Smear		
[ ] Physical Exam		
[ ] Cardiac Stress Test		
[ ] Ultrasound		

Check-In by

Consent for Voice and Text Messaging Communication

To relay **Normal results** faster for our patients we have implemented Electronic Medical Records. I understand that for Dr.Achille to leave detailed messages containing specific medical information on my voicemail or answering machine. I need to give my permission to Dr.Achille and Staff.

I further understand that for Dr.Achille to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Dr.Achille/Staff.

I also understand that my healthcare information at the practice is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages:
I give my written express consent to the practice (Dr.Achille and Staff) to leave detailed messages on my voicemail /answering machine about my **NORMAL** lab, ultrasound, breast imaging, prescription information, reminders, or PAP smear results. I also give my written express consent that this information may be communicated to me via Text message.

I UNDERSTAND THAT "SENSITIVE" INFORMATION AS NOTED WILL BE EXCLUDED.

- **No abnormal results** will be communicated via our automated system
- **No HIV results** are disclosed by phone, mail, email, or text. HIV results are only given in person to the patient as stipulated by the **H.I.P.P.A. Law.**

______________________________ ______________________________

Patient Name (Please Print) **Patient Signature**

______________________________ ______________________________

Date **Cell:** **(This number will be used for messaging)**

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.

I understand that I must provide written notice to the practice (Dr.Achille/Staff) to revoke this consent.

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 •
Fax (954)-833-2027

Fabienne Achille, MD., F.A.C.O.G

THIS TEST MAY NOT BE COVERED BY YOUR INSURANCE PLAN. BY SIGNING YOU AGREE TO PAY ALL COSTS INVOLVED FOR TESTING **PLEASE CALL YOUR INSURANCE CARRIER TO INQUIRE ON YOUR PRENATAL TESTING BENEFITS**

Patient Name:______________________________

CONSENT FOR INTEGRATED SCREEN

When a woman finds she's pregnant, she faces many choices. One important choice is whether to have a maternal serum screening test, such as Integrated Screen, to determine if she is at an increased risk of having a baby with certain birth defects such as Down Syndrome, trisomy 18, or open neural tube defects.

What is an integrated screen?
An integrated screen is a blood test that shows if you are at an increased risk of having a baby with Down Syndrome, trisomy 18, or an open neural tube defect. It requires a sample of your blood to be drawn between 11 to 13.6 weeks of pregnancy along with an ultrasound measurement of the baby's neck (Nuchal Translucency) performed at the Perinatologist's office in the first trimester of pregnancy (1-12 weeks), a second blood sample is taken between 16-18 weeks of pregnancy (second trimester).
The Nuchal Translucency measurements, combined with your first & second-trimester blood results will yield the final screening assessment.

What is Down Syndrome?
Down Syndrome is caused by the presence of an extra chromosome #21 and results in both mental and physical abnormalities. Approximately 1 in 800 babies is born with Down Syndrome, The risk of having a child with Down Syndrome gradually increases with the age of the mother, but can occur at any maternal age.

What is trisomy 18?
Trisomy 18 is caused by the presence of an extra chromosome #18 and results in serious mental challenges and physical deformities, including major heart defects. Approximately 1 in 6500 babies are born with trisomy 18. Only 1 out of 10 babies affected with trisomy 18 live past the first year of life. As with Down Syndrome, the risk of having an affected child gradually increases with the age of the mother.

What are open neural tube defects?
The neural tube, which forms very early in pregnancy, eventually develops into the baby's brain and spinal cord. If this tube does not close completely, an opening remains along the part of the baby's spine or head. This can lead to paralysis and other physical and/or mental problems. Open neural tube defects occur in about 1 out of every 1500 live births. The risk of having a child with a neural tube defect does not increase with the age of the mother.

Your specific test result is affected by:

- Exactly how far along you are in your pregnancy when the ultrasound and blood samples are done.
- Your weight, ethnic background, and age
- Whether you are an insulin-dependent diabetic or take certain types of medications
- Whether a close relative has Down Syndrome or an open neural tube defect

❒ **I want the Integrated Screen with genetic counseling** ❒ **NO testing at all**

______________________________ ________________
Patient Signature **Date**

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 • Fax (954)-833-2027

Fabienne Achille, MD., F.A.C.O.G

THIS TEST MAY NOT BE COVERED BY YOUR INSURANCE PLAN. BY SIGNING YOU AGREE TO PAY ALL COSTS INVOLVED FOR TESTING **PLEASE CALL YOUR INSURANCE CARRIER TO INQUIRE ON YOUR PRENATAL TESTING BENEFITS**

Patient Name:______________________________ **Date:**________________________

CONSENT FOR CARRIER TESTING SPINAL MUSCULAR ATROPHY (SMA)

SPINAL MUSCULAR ATROPHY (SMA) is an inherited disease that affects 1 in 35 to 1 in 117 in the U.S., varies by ethnicity. SMA is 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.

Inheritance

If your test shows that you are a carrier of SMA, the next step is for your partner to have carrier testing performed. Both parents must be carriers for the baby to be at risk of SMA. If your partner has a negative test result and no family history of SMA that chance that your baby will have SMA is less than 1%. If both parent carriers, there is a 1 in 4 (25%) chance to have a child with SMA.

Referral

We will arrange a consultation with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following points:

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

❒ I WANT SMA testing. ❒ **I DO NOT WANT SMA testing.**

____________________________ ____________________________

Patient Signature **Date**

Fabienne Achille, MD., F.A.C.O.G

THIS TEST MAY NOT BE COVERED BY YOUR INSURANCE PLAN. BY SIGNING YOU AGREE TO PAY ALL COSTS INVOLVED FOR TESTING **PLEASE CALL YOUR INSURANCE CARRIER TO INQUIRE ON YOUR PRENATAL TESTING BENEFITS**

Patient Name:____________________________________

Date:____________________________

CONSENT FOR CARRIER TESTING FRAGILE X SYNDROME

The most common inherited cause of mental challenges.
Fragile X syndrome involves developmental delay, mental challenges, autism, and hyperactivity. It primarily affects boys. Women who are carriers are at risk to have a child with mental challenges. Fragile X syndrome affects approximately 1 in 260 women and occurs in all ethnicities.

Inheritance
If a mother is a carrier, there is a 50% chance to have a child with Fragile X syndrome

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

Referral
We will arrange a consultation with the perinatologist for genetic counseling and additional testing if needed based on your results.

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

❒ **I WANT** Fragile X testing.

❒ **I DO NOT WANT Fragile X testing.**

____
Patient Signature

____
Date

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 • Fax (954)-833-2027

Fabienne Achille, MD., F.A.C.O.G

THIS TEST MAY NOT BE COVERED BY YOUR INSURANCE PLAN. BY SIGNING YOU AGREE TO PAY ALL COSTS INVOLVED FOR TESTING **PLEASE CALL YOUR INSURANCE CARRIER TO INQUIRE ON YOUR PRENATAL TESTING BENEFITS**

__________________________________**Patient Name:**__________________________________

CONSENT FOR CYSTIC FIBROSIS CARRIER TESTING

What is Cystic Fibrosis (CF)

Cystic fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. Symptoms of CF vary but include lung congestion, pneumonia, diarrhea, and poor growth. Most people with CF have severe medical problems and some die at a young age. Others have a few symptoms and they are unaware they have CF. CF does not affect intelligence. There is no cure for CF at this time. In the past, many people with CF have died at a very young age. Today, as a result of scientific advantages, many are living in their 20's and 30's.

Is there a chance my baby could have Cystic Fibrosis?

You can have a child with CF even if there is no history of it in your family. Carrier frequency is 1 in 30 average in the U.S., varies by ethnicity. CF testing can help determine if you are a carrier and are at risk to have a child with CF. If both parents carriers, there is a 1 in 4 (25%) chance, with each pregnancy, that they will have a child with CF. Carriers have one normal CF gene and one altered CF gene. People with CF have two altered CF genes. Most people have two normal copies of the CF gene.

Referral

We will arrange a consultation with the perinatologist for genetic counseling and additional testing if needed based on your results.

You should understand the following points:

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

❒ **I WANT** CF carrier testing.

❒ **I DO NOT WANT CF carrier testing.**

______________________________ **Patient Signature**

______________________________ **Date**

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 • Fax (954)-833-2027

I have been furnished information by Dr. Achille, prepared by the Florida Birth-Related Neurological Injury Compensation Association, and have been advised that Dr. Fabienne Achille is a participating physician in the program, wherein certain limited compensation is available in the certain neurological injury may occur 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, FL 32312. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure by NICA

In the event of an emergency or when Dr. Achille is on vacation, the physician will be the "On-Call" covering physician:

- **Dr. Emil Abdalla**
- **Dr. Leonardo Catalano**
- **Dr. Stefan Novac**

DATED this __________ day of ____________________, 20_____.

____

Signature

____

Name of Patient **(Please Print)**

____

Social Security

Attest:

____

Witness

____

Date

SEE SECTION 766.316, FLORIDA STATUTES

CONSENT TO HIV-1 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 antibody to HIV, it means that I may have been infected with HIV, which is believed to cause AIDS (Acquired Immune Deficiency Syndrome)

AT FIRST PRENATAL VISIT

- ❑ I authorize my health care providers to collect one or more blood specimens from me at the time of my first prenatal visit to detect whether or not I have antibodies in my blood to HIV-1 (human immunodeficiency virus). This is the *virus* that has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report the test results to me in person and not by telephone or 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 available to me.

CONSENT TO RELEASE

I understand that the test results will be confidential and only be disclosed to me in person at the office of Dr. Achille unless permitted or required by law. I hereby consent to the release of the test results to Dr. Achille. I understand Dr. Achille will comply strictly with the law regarding access to results by all staff

- ❑ **REFUSAL OF HIV-1 ANTIBODY TESTING**

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences. I refuse to give my consent for HIV testing.

This test is required by the hospital if testing is also declined at the admission of the hospital, testing will be done on your body.

Patient Signature	**Date**
Witness Signature	**Name of Patient (Please Print)**

- ❑ **Authorization for Repeat HIV Testing In The Third Trimester of Pregnancy**
  I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the re-test is performed and will provide me with the test results.
- ❑ **I Decline Repeat HIV Testing in the Third Trimester of Pregnancy**
  With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

Patient Signature	**Date**
Witness Signature	**Name of Patient (Please Print)**

NO PM VERSION OF ANY MEDICATIONS ALLOWED IN PREGNANCY

Medication Name	1st Trimester	2nd Trimester	3rd Trimester
ANTACIDS / REFLUX / UPSET STOMACH			
Aciphex (rabeprazole) Rx	Yes	Yes	Yes
Gas-X	Yes	Yes	Yes
Nexium (Lansoprazole) Rx	Yes	Yes	Yes
Pepcid (famotidine)	Yes	Yes	Yes
Pepto-Bismol (bismuth subsalicylate)	**No**	**No**	**No**
Plain Maalox, Mylanta, Tums, Rolaids	Yes	Yes	Yes
Prevacid (pantoprazole) Rx	Yes	Yes	Yes
Prilosec (omeprazole)	Yes	Yes	Yes
Protonix Rx (pantoprazole) Rx	Yes	Yes	Yes
Tagamet (cimetidine)	Yes	Yes	Yes
Zantac (ranitidine)	Yes	Yes	Yes
ANTIBIOTICS (all Rx)			
Amoxicillin, ampicillin Rx	Yes	Yes	Yes
Augmentin (amoxicillin + clavulanate) Rx	Yes	Yes	Yes
Bactrim (trimethoprim/ sulfamethoxazole) Rx	Yes	Yes	Yes
Cipro (ciprofloxacin), Levofloxacin (Levaquin) Rx	**No**	**No**	**No**
Clindamycin Rx	Yes	Yes	Yes
Doxycycline Rx	**No**	**No**	**No**
Erythromycin Rx	Yes	Yes	Yes
Keflex (cephalexin) Rx	Yes	Yes	Yes
Macrobid, Macrodantin (nitrofurantoin) Rx	Yes	Yes	**With Approval**
Metronidazole Rx	**No**	Yes	Yes
Tetracycline Rx	**No**	**No**	**No**
Zithromax (azithromycin) Rx	Yes	Yes	Yes
ANTI-DEPRESSANTS			
Discuss with provider/ NO Paxil (paroxetine)	**No**	**No**	**No**
ANTI-DIARRHEALS			
Imodium capsules (Loperamide)	Yes	Yes	Yes
Kaopectate (bismuth subsalicylate)	**No**	**No**	**No**
ANTI-EMETICS			
Doxylamine (Unisom sleep tabs)	Yes	Yes	Yes
Kytril (granisetron) Rx	Yes	Yes	Yes
Phenergan (promethazine) Rx	Yes	Yes	Yes
Reglan (metoclopramide) Rx	Yes	Yes	Yes
Zofran (ondansetron) Rx	Yes	Yes	Yes

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 • Fax (954)-833-2027

ANTIFUNGALS			
Diflucan (fluconazole) Rx	**No**	**No**	**No**
Gynazole 1 (butoconazole) Rx	**No**	Yes	Yes
Gyne-Lotrimin 3 or 7-day (clotrimazole)	**No**	Yes	Yes
Monistat 1-day (miconzole, ticonazole)	**No**	Yes	Yes
Monistat 3 or 7-day (miconazole)	**No**	Yes	Yes
ANTIHISTAMINES / DECONGESTANTS / COUGH / COLD			
Allegra (fexofenadine) Rx	Yes	Yes	Yes
Afrin nasal spray (oxymetazoline)	**No**	**No**	**No**
Benadryl (diphenhydramine)	Yes	Yes	Yes
Chlor-trimeton (chlorpheniramine)	Yes	Yes	Yes
Clarinex, Alavert, Claritin (Loratadine)	Yes	Yes	Yes
Cough Drops	Yes	Yes	Yes
Mucinex (guaifenesin)	Yes	Yes	Yes
Mucinex- D (guaifenesin + pseudoephedrine)	**No**	Yes	Yes
Phenylephrine	**No**	**No**	**No**
Robitussin Cough, Delsym (dextromethorphan)	Yes	Yes	Yes
Robitussin CF cough & cold (dextromethorphan + guaifenesin + phenylephrine)	**No**	**No**	**No**
Robitussin DM (dextromethorphan + guaifenesin)	Yes	Yes	Yes
Sudafed (pseudoephedrine)	**No**	Yes	Yes
Tylenol Cold & Flu	Yes	Yes	Yes
Zicam	Yes	Yes	Yes
Zyrtec (cetirizine)	Yes	Yes	Yes
ANTIVIRALS			
Famvir (famciclovir) Rx	Yes	Yes	Yes
Valtrex (valacyclovir) Rx	Yes	Yes	Yes
Zovirax (acyclovir) Rx	Yes	Yes	Yes
LAXATIVES / STOOL SOFTENERS			
Citrucel (methylcellulose powder)	Yes	Yes	Yes
Colace, pericolace (docusate sodium)	Yes	Yes	Yes
Dulcolax Tablets (bisacodyl)	Yes	Yes	Yes
Lactulose Rx	Yes	Yes	Yes
Milk of Magnesia	Yes	Yes	Yes
Miralax (PEG)	Yes	Yes	Yes
Senokot (senna)	Yes	Yes	Yes
PAIN / FEVER			
Aleve (naproxen sodium)	**No**	**No**	**No**
Aspirin	**No**	**No**	**No**
Motrin, Advil, (ibuprofen)	**No**	**No**	**No**
Tylenol (acetaminophen)	Yes	Yes	Yes
Tylenol with codeine Rx		**With Doctor Approval**	
TOPICAL CREAMS / OINTMENTS			
Benadryl, hydrocortisone, caladryl	Yes	Yes	Yes
Retin A	**No**	**No**	**No**
Proactiv	Yes	Yes	Yes

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026 • Phone (954)-833-2026 •
Fax (954)-833-2027