**ACOG Antepartum Record** Faxed To L&D: _____

Date: _____ DOB: _____ Age: _____

Name: _____

Last First Middle Initial

**G:**_____ **P:** _____

| **Problems/Plans (Drug Allergy**: _____) | **Medication List**: Start Date Stop Date |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| EDD Confirmation<br>Initial EDD<br>LMP: ____/____/____ EDD: ____/____/____<br>Initial Exam ____/___/____ WKS – EDD ____/____/____<br><br>LMP: ☐Definite Menarche _____ (AGE ONSENT)<br>☐Normal Amount Menses Monthly: **Y or N**<br>☐Approx. (Month Unknown) Frequency (date):_____<br>☐Unknown Prior Menses (date):_____<br>On BCPS at conception: **Y** or **N** | USS<br>Ultrasound ___/___/___ ____WKS= ___/___/___<br>Ultrasound ___/___/___ ____WKS= ___/___/___<br>Ultrasound ___/___/___ ____WKS= ___/___/___<br><br>Final EDD ___/___/____ Initialed by: _____<br><br>B-STREP _____ VBAC _____ C/S _____ |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Visit Date | | | | | | | | | | | | | | |
| Weeks Gest. Best est. | | | | | | | | | | | | | | |
| Ht. Fundus (cm) | | | | | | | | | | | | | | |
| Presentation YTX, BR, Transverse | | | | | | | | | | | | | | |
| FHR Present<br>F= Fetoscope O=Absent D=Doptone | | | | | | | | | | | | | | |
| Fetal Movement<br>+=Present D=Decreased O=Absent | | | | | | | | | | | | | | |
| Prematurity<br>SIGNS/SYMPTOMS<br>+=Present<br>0=Absent | Vaginal Bleeding | | | | | | | | | | | | | |
| | Mucus/Spotting/Discharge | | | | | | | | | | | | | |
| | Cramps/Contractions | | | | | | | | | | | | | |
| | Dysuria | | | | | | | | | | | | | |
| | Pelvic Pressure | | | | | | | | | | | | | |
| Cervix Exam (Dil./Eff./Sta.) | | | | | | | | | | | | | | |
| Blood Pressure | Initial | | | | | | | | | | | | | |
| | Repeat | | | | | | | | | | | | | |
| Edema | + = Present O = Absent | | | | | | | | | | | | | |
| Weight | | | | | | | | | | | | | | |
| Cumulative Weight Gain | | | | | | | | | | | | | | |
| Urine (Glucose/Albumin/Ketones) | | | | | | | | | | | | | | |
| Next Appointment | | | | | | | | | | | | | | |
| Provider | | | | | | | | | | | | | | |

| Patient Name: | | Birth Date: – – | ID No.: | Date: – – |
|---|---|---|---|---|

## Genetic Screening*

| Condition | Patient | Partner | Other | Relationship |
|---|---|---|---|---|
| Congenital Heart Defect | | | | |
| Neural Tube Defect | | | | |
| Hemoglobinopathy Or Carrier | | | | |
| Cystic Fibrosis | | | | |
| Chromosome Abnormality | | | | |
| Tay–Sachs | | | | |
| Hemophilia | | | | |
| Intellectual Disability/Autism | | | | |
| Recurrent Pregnancy Loss/Stillbirth | | | | |
| Other Structural Birth Defect | | | | |
| Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy) | | | | |

## Teratogen Exposures Since LMP/Pregnancy

| | Yes | No | Details/Date |
|---|---|---|---|
| Prescription Medications | | | |
| Over The Counter Medications | | | |
| Alcohol | | | |
| Illicit Drugs | | | |
| Maternal Diabetes | | | HGB A1C |
| **Other** | | | |
| Uterine Anomaly/DES | | | |

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

## Infection History

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Live with Someone with TB or Exposed to TB | | | 6. HIV Infection | | |
| 2. Patient or Partner Has History of Genital Herpes | | | 7. History Of Hepatitis | | |
| 3. Rash or Viral Illness Since Last Menstrual Period | | | 8. Recent Travel History or Partner Travel Outside of Country | | |
| 4. Prior GBS-Infected Child | | | 9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates. | | |
| 5. History of STIs: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID | | | 10. Other (See Comments) | | |

COMMENTS: _____

_____ INTERVIEWER'S SIGNATURE: _____

## Immunizations

| Immunizations | Yes (Month/Year) ____ / ____ | No | If No, Vaccine Indicated?* | Immunizations | Yes (Month/Year) ____ / ____ | No | If No, Vaccine Indicated?* |
|---|---|---|---|---|---|---|---|
| Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible) | | | | Hepatitis A (When Indicated) | | | |
| Influenza† (Each pregnancy as soon as vaccine is available) | | | | Hepatitis B (When Indicated) | | | |
| Varicella† | | | | Meningococcal (When Indicated) | | | |
| MMR (Rubella-containing vaccine)† | | | | Pneumococcal (When Indicated) | | | |
| HPV | | | | | | | |

*Yes/No and date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

## Initial Physical Examination

Date: _____ / _____ / _____ BP/Prepregnancy Weight: _____ Height: _____ BMI: _____

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Heent | | Normal | | Abnormal | 11. Vulva | | Normal | | Condyloma | | Lesions |
| 2. Teeth | | Normal | | Abnormal | 12. Vagina | | Normal | | Inflammation | | Discharge |
| 3. Thyroid | | Normal | | Abnormal | 13. Cervix | | Normal | | Inflammation | | Lesions |
| 4. Breasts | | Normal | | Abnormal | 14. Uterus Size | | Weeks | | | | Fibroids |
| 5. Lungs | | Normal | | Abnormal | 15. Adnexa | | Normal | | Mass | | |
| 6. Heart | | Normal | | Abnormal | 16. Rectum | | Normal | | Abnormal | | |
| 7. Abdomen | | Normal | | Abnormal | 17. Clinical Pelvimetry | | Concerns | | No Concerns | | |
| 8. Extremities | | Normal | | Abnormal | | | | | | | |
| 9. Skin | | Normal | | Abnormal | | | | | | | |
| 10. Lymph Nodes | | Normal | | Abnormal | | | | | | | |

COMMENTS (Number and explain abnormals): _____

_____ EXAM BY: _____



 

| Patient Name: | | Birth Date: – – | ID No.: | Date: – – |
|---|---|---|---|---|

| Laboratory and Screening Tests* | | | Reviewed | Comments/Additional Labs |
|---|---|---|---|---|
| **Initial Labs** | **Date** | **Result** | | |
| Blood Type | – – | A B AB O | | |
| D (Rh) Type | – – | | | |
| Antibody Screen | – – | | | |
| Complete Blood Count | – – | HCT/HGB: _____ % _____ g/dL<br>MCV:_____<br>PLT:_____ | | |
| VDRL/RPR (Syphilis) | – – | | | |
| Urine Culture/Screen | – – | | | |
| HBsAg | – – | | | |
| HIV Testing | – – | Pos. Neg. Declined | | |
| Chlamydia | – – | | | |
| Gonorrhea (When Indicated) | – – | | | |
| Rubella Immunity | – – | | | |
| Other: | | | | |
| **Supplemental Labs** | **Date** | **Result** | | |
| Hemoglobin Electrophoresis | _ _ | AA AS SS AC | | |
| PPD/Quanta (When Indicated) | – – | | | |
| Pap Test (When Indicated) | _ _ | | | |
| HPV (When Indicated) | _ _ | | | |
| Early Diabetes Screen (When Indicated) | _ _ | Pos. Neg. Declined | | |
| Varicella Immunity (When Indicated) | _ _ | | | |
| Cystic Fibrosis | _ _ | Pos. Neg. Declined | | |
| Spinal Muscular Atrophy | – – | Pos. Neg. Declined | | |
| Fragile X | – – | Pos. Neg. Declined | | |
| Tay–Sachs | – – | Pos. Neg. Declined | | |
| Canavan Disease | – – | Pos. Neg. Declined | | |
| Familial Dysautonomia | – – | Pos. Neg. Declined | | |
| Genetic Screening Tests (See Form B) | _ _ | Pos. Neg. Declined | | |
| Zika Virus (When Indicated, All Trimesters)† | – – | | | |
| Other: | | | | |
| **8–20-Week Aneuploidy Screening** | **Date Test Performed** | **Result** | | |
| Aneuploidy Screening Offered | – – | Accepted Declined GA Too Advanced | | |
| 1st Trimester Aneuploidy Screening | – – | Pos Neg | | |
| 2nd Trimester Serum Screening | – – | Pos Neg | | |
| Integrated Screening | – – | Pos Neg | | |
| Cell-Free DNA | – – | Pos Neg | | |
| CVS | _ _ | Karyotype: 46,XX Or 46,XY/Other_____<br>Array | | |
| Amniocentesis | _ _ | Karyotype: 46,XX Or 46,XY/Other_____<br>Array | | |
| Amniotic Fluid (AFP) | – – | Normal Abnormal | | |
| Other: | | | | |

*(continued)*

*For serologic test results, rubella status, hepatitis B results, HIV status, GBS, Zika, and other maternal test results that are relevant to neonatal care, please attach lab results
†Check cdc.gov/zika for updates.

PROVIDER SIGNATURE (AS REQUIRED): _____

 

| Patient Name: | | Birth Date: – – | ID No.: | Date: – – |
|---|---|---|---|---|

## Laboratory and Screening Tests *(continued)*

| Late Pregnancy Labs and Screening | Date | Result | Reviewed |
|---|---|---|---|
| Complete Blood Count | – – | HCT/HGB:_____ % _____ g/dL<br>MCV:_____<br>PLT:_____ | |
| Diabetes Screen (24–28 Weeks) | – – | | |
| GTT (If Screen Abnormal) | – – | _____Fbs _____1 Hour<br>_____2 Hours _____3 Hours | |
| D (Rh) Antibody Screen (When Indicated) | – – | | |
| Anti-D Immune Globulin (RhIg) Given (28 Wks Or Greater) (When Indicated) | – – | _____<br>Signature | |
| Ultrasonography (18–24 Weeks) (When Indicated) | – – | | |
| HIV (When Indicated)‡ | – – | | |
| VDRL/RPR (Syphilis) (When Indicated) | – – | | |
| Gonorrhea (When Indicated) | – – | | |
| Chlamydia (When Indicated) | – – | | |
| Group B Strep (35–37 Weeks) | – – | | |
| Resistance Testing If Penicillin Allergic | – – | | |
| Other: | | | |

**Comments/Additional Labs**

‡Check state requirements before recording results.

## Comments

PROVIDER SIGNATURE (AS REQUIRED): _____

 

**Name:** _____ **Today's Date:**_____

**D.O.B:** _____ **Race:** _____

**Age:** _____ **Marital Status:** M S W D

**OCCUPTATION:** _____

**EMERGENCY CONTACT:**

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

DATE OF FIRST DAY OF LAST MENSTRUAL PERIOD: _____

(Please Circle Yes or No for below questions)

DEFINATE: **YES/NO**

UNKNOWN: **YES/NO**

DID YOU TAKE BIRTH CONTROL DURING CONSEPTION: **YES/NO**

IS A BLOOD TRANSFUSION ACCEPTABLE: **YES/NO**

ARE YOU ALLERGIC TO LATEX: **YES/NO**

| | | | |
|---|---|---|---|
| TOTAL NUMBER OF PREGNANCIES: _____ | FULL TERM: _____ | PREMATURE: _____ | ABORTIONS: _____ |
| | MISSCARIAGES: _____ | MULTIPLE BIRTHS: ___ | LIVING: _____ |

**PAST PREGNANCIES (LAST SIX):**

| Date (MM/DD/YR) | Weeks of Gestation: | Length of Labor: | Weight of Baby: | Type of Birth: | Male or Female: | Hospital Delivered at: | Preterm Labor: (Y/N) | Complication? (Y/N, if yes please specify) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

# HIV Testing Acknowledgment

I have been informed that a sample of my blood will be obtained and tested to determine the presence of antibodies to Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

I understand that my HIV test results will become a part of my For Women Only, Ob/Gyn Specialists of Fort Lauderdale (the "Office") medical records. I further understand that, except as indicated below, the Office will not disclose the fact that I have been tested for HIV or the results of my HIV test to anyone unless:

(i) I specifically direct the Office to do so;

(ii) Such disclosure is provided or required by law;

(iii) Pursuant to a valid court order

The Office will provide my HIV test results to the following individuals/entities:

1. To me or my legally authorized representative;
2. To Office agents participating in my medical care and treatment and have a need to know such information;
3. My healthcare providers for the purpose of diagnosis and treatment;
4. To third party payors (such as my insurance provider).

Under Florida law the Office is required to report the names of individuals who test positive HIV to the local health department.

I understand that anonymous HIV testing is available to me and that the Office will provide me with a list of local clinics where I can be tested anonymously at my request.

I have read and understand the above information. I have been advised of the nature of the HIV test; what the results mean and the benefits and risks of being tested. I understand that I have the alternative of not being tested. I hereby authorize the Office to perform this test.

Patient Signature:_____

Patient Print:_____

Date:_____

Patient Representative (for minors under 18):_____

Relationship to minor Patient:_____


# NOTICE TO OBSTERIC PATIENTS

(See Section 766.316, Florida Statutes)

I have been advised that doctors Rachel Bernstein and Patricia Calvo are participating physicians in the Florida Birth-Related Neurological Injury Compensation Association, wherein certain limited compensation is available in the event of certain neurological injury which 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, PO Box 14567 Tallahassee, Florida 32317-4567, or at 800-398-2129.

Dated this _____ day of _____, 20____

_____ _____

Signature of Patient Social Security No.

_____

Printed Name of Patient

Attest:

_____ _____

Signature of Physician Date

Rachel Bernstein MD, FACOG ● Patricia Calvo MD, FACOG

6333 North Federal Highway, Suite 285, Fort Lauderdale, Florida 33308 ● 954-770-2141 Fax 754 206 4774

www.ForWomenOnlyOBGYN.com

For Women Only
Ob/Gyn Specialists of Fort Lauderdale

# NIPS – Non-Invasive Prenatal Screening

As a part of your prenatal care, ObGyn Specialists of Fort Lauderdale performs a screening test via blood draw between 10-12 weeks called the Non-Invasive Prenatal Screening, also known as NIPS.

This test is screening the baby's DNA, through the mother's bloodstream, for chromosomal abnormalities. NIPS is a screening test, meaning it determines whether the baby is at an increased or decreased risk for the following conditions: Trisomy's 13, 18 and 21, Monosomy X and Triploidy. If a higher risk is identified, additional diagnostic testing may be recommended.

This screening test is medically recommended by the American College of Obstetrics and Gynecology. It is not only a way to identify these abnormalities but is also a way for us to ensure that both mom and baby are in the best care possible if a chromosomal abnormality is present.

The NIPS also results the **gender** of the baby and is 100% accurate since it is DNA based, however the office staff will ALWAYS ask you before revealing the gender because we know some patients don't always want to know.

Please note that this screening test cannot detect all genetic changes that could cause health problems. Low Risk results do not guarantee a healthy pregnancy or baby.

ObGyn Specialists of Fort Lauderdale uses **Natera** to perform this test. If you would like additional information, you can schedule a free, 15-minute information session with a certified genetic counselor by calling 855-866-6478 or visiting www.naterasession.com

By signing below, you are consenting that you would like ObGyn Specialists of Fort Lauderdale to perform the NIPS as a part of medical recommendations by the American College of Obstetrics and Gynecology:

_____ _____

Patient Signature Date

Rachel Bernstein MD, FACOG ● Patricia Calvo MD, FACOG

6333 North Federal Highway, Suite 285, Fort Lauderdale, Florida 33308 ● 954-770-2141 Fax 754 206 4774

www.ForWomenOnlyOBGYN.com

# Carrier Screening in Pregnancy for Common Genetic Diseases

Everyone has a risk to having a baby with problems. There are a few common disorders that can occur without a family history that you will be tested for. It's one simple blood test **before the baby is born** to determine if you carry a gene (DNA change) that causes the disorders shown below.

**What is a carrier?**
A carrier is a person who has a gene that increases the risk to have children with a genetic disease. People do not know if they are carriers until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders occur only when the mother is a carrier.

**What is carrier screening?**
Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk that their baby is affected. If you turn out to be at risk, genetic counseling or additional prenatal testing such as amniocentesis or chorionic villus sampling (CVS) is available to determine if your unborn baby is affected.

**Medical Recommendations**
The American College of Obstetrics and Gynecology recommends that every patient who becomes pregnant or would like to become pregnant have a Genetic Carrier Screen to detect the following common genetic diseases that could affect the baby. It is a single panel of 14 diseases/disorders. (**IF** you have another disease or disorder, not listed below, that you **KNOW** runs in your family, please let your Physician know because we may be able to test for the carrier in a larger panel.) This particular panel, called the Horizon 14, is the one RECOMMENDED by the American College of Obstetrics and Gynecology. It is also our Standard of Care to ensure each patient who becomes pregnant and is seen in our office has this test done so we can learn as much as we can about the pregnancy and to ensure that mom and baby are in the best care possible at all times.

You will be tested to see if you are a carrier of the following 14 common genetic diseases:

-Cystic Fibrosis
-Fragile X Syndrome (mental retardation)
-SMA- Spinal Muscular Atrophy
-Duchenne/Becker Muscular Dystrophy
-Alpha-thalassemia
-Beta-hemoglobinopathies
-Tay-Sachs Disease
-Canavan Disease
-Gaucher Disease
-Familial Dysautonomia
-Galactosemia
-Polycystic Kidney Disease- Autosomal Recessive
-Smith-Lemli-Opitz Syndrome
-Medium Chain Acyl-CoA Dehydrogenase Deficiency

You will have a chance to go over the insurance coverage and pricing for this test when you have your first Prenatal visit and go over your New OB folder.

PATIENT SIGNATURE: _____ DATE: _____

For Women Only
Ob/Gyn Specialists of Fort Lauderdale

# Drug and Alcohol Screen-General Consent

As a part of my prenatal care, I hereby CONSENT to allow, ObGyn Specialists of Fort Lauderdale, to perform a drug and alcohol screening via urine or blood sample to test for any drug or alcohol use. I FURTHER CONSET to allow the laboratory testing service to make the results of such screen available to my Physician at ObGyn Specialists of Fort Lauderdale.

In consideration for such services being rendered on my behalf, I hereby RELEASE the laboratory testing service, its officers, agents and employees, from any and all claims which I might otherwise have due to such results being made available. I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against ObGyn Specialists of Fort Lauderdale, the laboratory testing service, their respective officers, agents or employees in connection with the results of such screen being made so available, and I hereby agree to INDEMNIFY and SAVE HARMLESS ObGyn Specialists of Fort Lauderdale, the laboratory testing service, their respective officers, agents, and employees from all damages, expenses, reasonable attorney's fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screening results being made available.

Please note: Your insurance will be billed for this screening test. Most insurance plans have coverage for labs, however based on the contract you have with your carrier, you may be responsible for part or all of the cost of the test.

SIGNED this _____ day of _____, 20_____

_____
Patient Signature

_____
Patient Print

Rachel Bernstein MD, FACOG ● Patricia Calvo MD, FACOG

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# Maternal Serum AFP Quad Screen

This blood test is routinely offered to pregnant patients as a screening test. This screening test is used to detest pregnancies that are at a high risk for open neural true defects, Down Syndrome or possibly other chromosome abnormalities. This screening test is usually performed between 16 and 18 weeks of your pregnancy.

The maternal serum AFP quad screen was not designed to be a diagnostic test; it is only a screening test. Test results outside the normal range do not mean that your baby has been diagnosed with a birth defect. If your test results are outside the normal range, further evaluation of your pregnancy is indicated. There are several options used for follow up testing depending on your circumstances, for example: Level I ultrasound to verify to gestation age of your pregnancy, Level II ultrasound used to identify abnormalities, genetic counseling and/or amniocentesis to detect abnormalities.

For some couples the maternal serum AFP quad screening provides reassurance that the pregnancy is not at high risk for certain birth defects. However, screening tests can lead to temporary worry and sometimes to risks from further testing. The maternal serum AFP quad screen is purely optional.

It is important to remember that no test or group of tests guarantees a health baby. There is a 3 to 5% chance of birth defects despite optimal medical care.

I certify that I understand the potential benefits and limitations of the maternal serum AFP quad screen.

I **DO / DO NOT** wish to have the maternal serum AFP quad screen performed.

_____ _____

Patient Signature Date

For Women Only
Ob/Gyn Specialists of Fort Lauderdale

# Obstetrical Medicaid Acknowledgment

## PLEASE READ IN FULL

Before you begin your pregnancy journey with us, we want to make sure you understand that we do **NOT** accept **ANY** form of Medicaid whether as a Primary or a Secondary insurance.

If you currently have or plan to switch to Medicaid, Secondary Medicaid, Sunshine Health or any Medicaid related products please notify us **IMMEDIATELY**.

Neglecting to notify the office of your participation in any Medicaid program may result in **immediate discharge** from our office as well as out of pocket fees that will be your responsibility.

I have read and understand the above statement and agree to notify the office of any current or future changes:

_____ _____

Patient Print Date

_____

Patient Signature

Rachel Bernstein MD, FACOG ● Patricia Calvo MD, FACOG

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