The Fertility Center

William Dodds MD, James Young MD, Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

3230 Eagle Park Dr. NE, Suite 100
Grand Rapids MI 49525
616.988.2229
877.904.4483

317 S. Drake Rd., Suite B
Kalamazoo MI 49009
269.324.5100
877.500.1658

1100 S. Cedar St., Suite B
Mason MI 48854
877.904.4483

FAX TRANSMITTAL MEMO

Please fax, mail or email (medrec@mrivf.com) new patient paperwork to the Grand Rapids office for appointments in Grand Rapids, Traverse City or Mason and to the Kalamazoo office for appointments in Kalamazoo.

DATE:_____

TO: The Fertility Center – New Patient Paperwork Processing

FAX #: Grand Rapids – (616) 988-2010
Kalamazoo – (269) 324-5041

FROM:_____

NUMBER OF PAGES INCLUDING THIS COVER:_____

Notes:_____

_____

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Please be advised that you are electing to send sensitive information to our office through methods that may not be secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. The Fertility Center cannot be responsible for material sent from unsecure servers. If you have any questions, please contact our office at 616-988-2229.

Appointment Date: _____ Office Location: _____

Female Patient

First Name: _____ Middle Initial: _____ Last Name: _____ Maiden Name: _____

Street Address: _____City: _____ State: _____ Zip: _____

A *detailed* voice message may be left at the following phone number: (____)_____

Date of Birth: _____ Age: _____ SS#: XXX-XX-_____ Marital Status: _____

Race (optional): _____ Ethnicity (optional):_____ Military Status/Branch: _____

Email address: _____

Patient's Employer: _____Address:_____City:_____State:____Zip:_____

Phone: (___)_____Date Employed: _____to_____ Full Time/Part Time

Emergency Contact:_____Relationship to Patient: _____

Telephone Number: (___)_____Alternate Name/Number:_____

Referring Physician: _____Telephone Number: (____)_____

Family Physician: _____Telephone Number: (____)_____

Partner - Please select one of the following (Required): Male_____, Female_____, No Partner _____

First Name: _____ Middle Initial: _____ Last Name: _____ Maiden Name: _____

Street Address: _____City: _____ State: _____ Zip: _____

A *detailed* voice message may be left at the following phone number: (____)_____

Date of Birth: _____ Age: _____ SS#: XXX-XX-_____ Marital Status: _____

Race (optional): _____ Ethnicity (optional):_____ Military Status/Branch: _____

Email address: _____

Patient's Employer: _____Address:_____City:_____State:____Zip:_____

Phone: (___)_____Date Employed: _____to_____ Full Time/Part Time

Emergency Contact:_____Relationship to Patient: _____

Telephone Number: (___)_____Alternate Name/Number:_____

Referring Physician: _____Telephone Number: (____)_____

Family Physician: _____Telephone Number: (____)_____

How did you hear about The Fertility Center? (Please check all that apply)

☐ **Referred by a Physician** ☐ **Friend/Family Member** ☐ **Internet Search** ☐ **Social Media**

Physician Name: _____ ☐ Facebook ☐ Instagram

Specialty: _____

City: _____ ☐ **Other:** _____

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Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

(*Please print all information. Authorization is in effect for 12 months with a mandatory requirement of updating annually, unless an earlier termination date is specified. (see below)*

Patient Name: _____ **Partner to:** _____
'Patient' refers to the person completing this form

Patient Social Security Number: XXX-XX-_____ **Patient Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize ***the practice (identified below)*** to disclose or provide protected health information, about me to the individual(s) listed below.

Practice Name: Michigan Reproductive and IVF - dba – The Fertility Center

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI)**:**

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **Entire patient record; or check only those items of the record to be disclosed**:

☐ office notes ☐ lab results ☐ x-rays; hospital ☐ financial history report (previous 3 years only).

☐ record of HIV and communicable disease testing ☐ record of mental health or substance abuse treatment

Purpose of disclosure (please check patient request or record the purpose of the disclosure)**:**

☐ Patient Request ☐Other (please specify): _____

Expirations or termination of authorization: This authorization will expire 12 months from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the date of your last signature to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. ***Please list date of expiration if earlier than 12 months from date of last signature)***: _____.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. (You have the right to receive a copy of signed authorizations upon request.)

_____ _____(expires in 12 months)
Patient signature date

FINANCIAL POLICY

Insurance coverage for infertility varies. Many insurance companies do not cover infertility. For this reason, we ask that you pay all fees at the time of service. We do not offer payment arrangements for any services. Financing is available through Advance Care. Please contact the billing department for more information.

We will submit a claim as a courtesy for all services rendered except for Tricare, VA, BCN Lab Services, and Medicaid. Please provide us with your current insurance information. If your insurance changes, please update us as soon as possible to ensure your claim is submitted correctly and timely. **Please note that your insurance policy is a contract between you and your insurance company, therefore, it is your responsibility to know and understand your contractual obligations and limitations.**

During the course of your treatment at The Fertility Center, you may wish to have a telephone consult. Telephone consults are billed to insurance companies, are rarely covered, and will be the patient's responsibility.

During your treatment plan, should you have an ultrasound at another facility, there is a $115 per cycle outside monitoring fee that is not billable to your insurance company.

Should you be interested in pursuing ART (Assisted Reproductive Technologies), you must initially pay a non refundable ART Case Management fee in order to reserve a month for your procedure. Your actual procedure **must** be prepaid prior to your procedure. A financial consult will be done so that you will have an approximate range for costs of your procedure.

In some cases, surgery may be required to treat your condition. We will bill your insurance for this, however, if you have insurance we do not participate with, you will be required to pay in full for your surgery within 30 days of the procedure.

Any outstanding balances must be resolved prior to beginning each treatment cycle. However, in the event of an emergency, care will be provided regardless of outstanding financial obligations.

Failure to pay any balances in a timely manner will result in a referral to a collection agency. In addition to the effect collection action will have on your credit rating, future services by The Fertility Center will not be provided until the balance is paid in full.

When obtaining a copy of your personal medical record for services rendered by The Fertility Center, we do not institute a monetary charge for the dissemination of a single copy of your record. A request for two or more copies of your personal medical record is subject to a $25.00 administrative fee.

For your convenience, we accept the following forms of payment: cash, check, credit card, and money order. We charge a service fee of $25.00 for all returned checks. **All office fees are approximate and subject to change without notice.**

No Show policy: We require 48 hours notice to cancel an appointment. You will be charged ½ the visit cost if you fail to show or contact the office. You will be charged $25.00 if you contact the office in less than 48 hours. There will be no charge if you cancel with a 48 hour notice. A credit card will be required to schedule a new patient appointment in event of a no show. There is a $50 no show fee for retrograde appointments in our lab.

Should you have any questions please feel free to contact our office at (616) 988-2229, ext. 102.

Acknowledgement of Payment Responsibility

I have read and understand the Financial Policy of The Fertility Center and agree to its terms. I understand that I am financially responsible for any services provided by The Fertility Center, including any items denied or not covered by my insurance and any yearly deductible or co-payment amounts. I acknowledge all outstanding balances for services are to be resolved within 30 days.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

12/16 (Patient or Parent/Guardian if minor)

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices: _____

Patient initials

The Fertility Center

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CONSENT FOR TREATMENT

Knowing that I require diagnostic testing, medical treatment or hospitalization, I voluntarily consent to the medical treatment deemed necessary in the judgment of my treating physicians. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of examination, tests, or treatments. I understand that if major diagnostic studies or treatment procedures such as surgery are required, I will be asked to give specific consent to those procedures. If I am an obstetrical patient, I understand that my signature consents to the care and treatment of my fetus.

MY MEDICAL INFORMATION

I understand that The Fertility Center will keep my medical information according to state law, federal law, and policy. I also understand that my information will be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes treatments and medicine or prescription information about me, including drug or alcohol use. In some cases, The Fertility Center is required by law to report information to an agency like the health department. This may prevent other diseases. I understand I can ask additional questions before signing this consent.

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____
Patient Name (Please Print) DOB

_____ _____
Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

William Dodds MD, James Young MD,
Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

CONSENT FOR HIV TESTING

HIV (Human Immunodeficiency Virus) infection is a long-term illness that damages the body's immune system and its ability to fight diseases. HIV can cause AIDS (Acquired Immunodeficiency Syndrome), the stage of HIV when the body is weakened and less able to fight off germs. HIV spreads through blood, semen, vaginal fluids, and breast milk. You can get or give an HIV infection by having vaginal, anal, or oral sex without a condom or sharing needles or works when injecting drugs. An infected mother can pass HIV to her child during pregnancy, birth or breastfeeding. You cannot get HIV by donating blood or through casual contact like hugging or shaking hands.

People can have HIV for years and not know it unless they get tested. If you **are infected**, it can help you get proper treatment and learn how to avoid spreading HIV to other people. If you **are not infected**, it can help you learn how to reduce your risk of getting HIV.

HIV testing: A **negative result** means you are not infected with HIV or you have a recent infection, too early to show up positive. If you have been exposed to HIV in the last six weeks, the test may not detect a new infection. A **positive result** means you are living with HIV. This means you can pass your infection to others through sex, sharing needles, through birth or breastfeeding. You should take precautions to avoid infecting others.

I understand I can ask additional questions before signing this consent and may ultimately refuse to sign it. My physician will review my treatment options at The Fertility Center, should I refuse HIV testing. I understand HIV test results are confidential and shall not be released without my permission, except as permitted under state law. I understand that I have a right to have this test done without the use of my name at any Michigan Department of Health-approved HIV counseling and testing site.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results. I understand that I have the right to withdraw my consent for the test at any time before the test is complete. By my signature below, I consent to be tested for HIV.

☐ I consent to HIV Testing.
☐ I do not consent to HIV Testing

_____ _____
Patient Signature Date

**Please Note: Our credentialing agencies require that all In Vitro Fertilization (IVF) patients complete this test.*

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____
Patient Name (Please Print) DOB

_____ _____
Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

3230 Eagle Park Dr. NE Suite 100
Grand Rapids, MI 49525
616-988-2229

317 S. Drake Rd., Suite B
Kalamazoo, MI 49009
269-324-5100

1100 S. Cedar St., Suite B
Mason MI 48854
616-988-2229

Physicians: William Dodds, MD
James Young, MD
Valerie Shavell, MD
Mili Thakur, MD

Patient Name: _____

DOB: _____

Review of Systems/Medical History

Do you consistently have any of the problems listed below that are not currently being treated or evaluated by another physician? Please check **Yes** or **No** and explain any Yes answers in the space provided.

Constitutional Symptoms	YES	NO
Activity change	☐	☐
Appetite change	☐	☐
Chills	☐	☐
Sweating at night	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight loss	☐	☐
Other_____		

HEENT	YES	NO
Ear discharge	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Ears ringing	☐	☐
Nosebleeds	☐	☐
Congestion	☐	☐
Runny nose	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Hoarse voice	☐	☐
Other _____		

Eyes	YES	NO
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Eye redness	☐	☐
Light sensitivity	☐	☐
Vision changes	☐	☐
Other _____		

Cardiovascular	YES	NO
Chest pain	☐	☐
Palpitations/racing heart	☐	☐
Difficulty breathing while lying down	☐	☐
Leg pain with walking	☐	☐
High cholesterol	☐	☐
Other _____		

Gastrointestinal	YES	NO
Trouble swallowing	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Fecal incontinence	☐	☐
Rectal pain	☐	☐
Rectal bleeding	☐	☐
Blood in stool	☐	☐
Other _____		

Genitourinary	YES	NO
Flank pain	☐	☐
Urinary incontinence	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Difficult urination	☐	☐
Urinary frequency	☐	☐
Menopausal symptoms	☐	☐
Heavy menses	☐	☐
Painful menses	☐	☐
Other _____		

Musculoskeletal	YES	NO
Neck pain	☐	☐
Back pain	☐	☐
Joint pain/swelling	☐	☐
Muscle pain	☐	☐
Gait problems/falls	☐	☐
Osteoporosis	☐	☐
Other _____		

Neurological	YES	NO
Headaches	☐	☐
Dizziness/light headed	☐	☐
Speech difficulty	☐	☐
Loss of consciousness	☐	☐
Seizures/tremors	☐	☐
Numbness/tingling	☐	☐
Weakness	☐	☐
Other _____		

Endo/Heme/Aller	YES	NO
Blood transfusions	☐	☐
Adenopathy	☐	☐
Bruise/bleed easily	☐	☐
Env. allergies	☐	☐
Excessive thirst	☐	☐
Frequent thirst	☐	☐
Other _____		

Psychiatric	YES	NO
Depression	☐	☐
Suicidal ideas	☐	☐
Anxiety	☐	☐
Hallucinations	☐	☐
Self-injury	☐	☐
Sleep disturbance	☐	☐
Hyperactivity	☐	☐
Behavior problems	☐	☐
Decreased concentration	☐	☐
Other _____		

Skin	YES	NO
Itching	☐	☐
Color change	☐	☐
New/changed spots	☐	☐
Rash	☐	☐
Wound	☐	☐
Nail changes	☐	☐
Hair changes	☐	☐
Breast pain	☐	☐
Breast mass/lump	☐	☐
Nipple discharge	☐	☐
Other _____		

Respiratory	YES	NO
Cough	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Chest tightness	☐	☐
Snoring	☐	☐
Choking	☐	☐
Sputum production	☐	☐
Other _____		

_____ _____

Patient Name (Print and Sign) Date

_____,MD _____

Signature of Physician Date

The Fertility Center

Families Happen Here

Hello and welcome!

My name is Mary DeGrandchamp and I am the genetic counselor at The Fertility Center. I'd like to tell you a little about my role, as you may be offered or have interest in an appointment with me during your journey with us. Genetic counselors have specialized training to support and empower individuals in making informed choices about their genetic health.

At The Fertility Center, we strive to provide excellent patient-centered care, and we recognize that genomics is a vital part of personalized medicine. While there are many causes of infertility and the vast majority of babies are born healthy, there can be great value in identifying potential genetic factors before a pregnancy is conceived.

- A Preconception Genetic Questionnaire is included in your new patient paperwork, which can help us identify genetic factors that may be important to your treatment plan and may allow you to bring up concerns about your personal or family health history.
- All patients are offered the option of carrier screening for common genetic diseases. Please review the attached handout on carrier screening, which will be discussed at your New Patient visit.

While not every person will need or desire genetic counseling, we want you to be aware of some reasons a genetic consult may be recommended or considered:

- Personal or family history of a known or potential genetic condition
- Carrier of a genetic condition or chromosome abnormality
- Advanced parental age (women and men)
- History of recurrent miscarriages
- Primary ovarian insufficiency
- An interest in IVF with preimplantation genetic testing (PGT)
- Undergoing treatment with an egg, sperm, or embryo donor with questions about the donor's genetic test results or family history
- Further questions about a genetic test that was recommended or offered by your physician

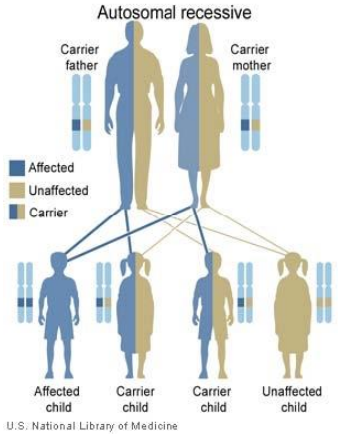
I work out of the Grand Rapids location daily, in Suite 201. If you are interested in setting up a genetic counseling appointment, please call our scheduling department at 616-988-2229, Ext. 122. If you have questions regarding the financial aspects of a consult, please contact our billing department at 616-988-2229, Ext. 102. If you would like additional information, please reach out to me at the contact information provided below. Whether or not our paths cross, I truly hope that your treatment with us is successful.

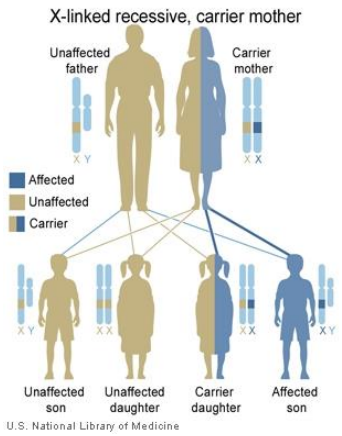
Sincerely,

Mary DeGrandchamp

Mary DeGrandchamp, MS, CGC Certified Genetic
Counselor Phone: 616-988-2229, Ext.128
Email: tfcgenetics@mrivf.com

Preconception Carrier Screening





Purpose of carrier screening:

- It is a DNA test that investigates whether you have ("carry") gene changes – also called mutations – that could cause certain significant genetic diseases in your children**.**
- For most of the conditions tested, both partners must carry a mutation in the same gene to have a 25% chance of having a child with the disease. However, there are certain conditions where only the mother needs to carry the mutation for her children to be at risk.

Why consider carrier screening?

- Many professional societies recommend carrier screening for individuals considering building a family, but testing is always optional.
- It is common to carry a change in one or more genes. Carriers are typically asymptomatic and often have no family history of the genetic condition. Some conditions are more common in certain ethnic groups, but anyone can be a carrier.
- Carrier screening may not be the right choice for everyone but testing before pregnancy will enable couples to make informed decisions when planning their family and/or allow for early diagnosis and care for their children.

What types of conditions are screened for?

Your testing includes >150 different genetic conditions. No carrier screen test includes every genetic condition and it is not always clear how serious or mild a condition could be based on the genetic testing results. The conditions on carrier screening tests are typically included because of the disease frequency in the population and because they fall into at least one of these categories:

- Reduces life expectancy
- Affects quality of life
- Early onset
- Early treatment benefits
- Impacts intellectual ability

Examples of conditions tested:

- Spinal muscular atrophy
- Cystic Fibrosis
- Hearing loss/deafness
- Phenylketonuria (PKU)
- Fragile X syndrome
- Sickle cell anemia

If you have specific familial genetic risks, it is your responsibility to let us know so we can discuss and order the appropriate tests, if available.

What happens if you do the test?

Results will be emailed to you by Myriad. Occasionally you may hear from our clinic first. Myriad has complimentary genetic counseling available by phone and we encourage you to review results with them. They will provide a consult note which can be helpful when sharing information with your relatives and providers.

-Screen negative: Significantly reduces, but cannot eliminate, the possibility that you are a carrier of the conditions that were tested. Typically, no further testing is recommended.

+Screen positive: You were identified as a carrier of the indicated condition(s). Typically, the next step is carrier screening for your partner. If you are at high-risk of passing on the condition to your children, our clinic's genetic counselor will meet with you to discuss reproductive options.

- There is always a possibility of unexpected or uncertain results. Testing may identify a condition that could impact your own current or future health.

- Keep in mind that it can take 2-3 weeks to receive results so couples should consider testing 1-2 months prior to attempting conception.

Blood Draw

- Your blood is drawn at The Fertility Center, and the sample is sent to the lab

Myriad will email and/or text you the cost of the test, with explanation (i.e. unmet deductible, co-insurance).

Options:

- Financial assistance
- Payment plan
- Contact Myriad ASAP if any desired changes or you want to cancel the test

Results will be emailed to you

- Contact Myriad for a phone consult with a genetic counselor: 888-268-6795
- Test your partner, if needed
- The Fertility Center genetic counselor will follow-up with you for high-risk results

If authorization for genetic testing is required by your insurance, Myriad often initiates this process. Myriad will reach out to our clinic if supporting documentation or additional information is needed.
Please call Myriad if you have specific billing questions or concerns, 888-268-6795.

If your partner needs testing, you can call The Fertility Center to schedule a blood draw or order a saliva kit through your Myriad account. If you have further questions *after* your consult with Myriad, please contact our genetic counselor, Mary DeGrandchamp at tfcgenetics@mrivf.com or 616-988-2229 ext. 128.

If you previously declined genetic carrier screening and have changed your mind, please contact our office or let your provider know. You will need to sign a consent form and schedule a blood draw.

More information about carrier screening, genetics, and Myriad's testing process can be found at https://myriadwomenshealth.com/patient/foresight-carrier-screen/

Watch a video
to learn more about
carrier screening
Text "CARRIER" to 99150

The Fertility Center

Reproductive Genomics Program at The Fertility Center
Preconception Screening Questionnaire

Patient Name: _____Date of Birth: _____

Partner Name: _____Date of Birth: _____

This questionnaire is designed to identify potential genetic concerns that may impact your treatment plan. The Fertility Center offers genetic counseling services. The purpose of a genetics consult is to review significant history, assess the reproductive risk to offspring, and discuss the option of genetic testing when applicable.

You and/or your partner were adopted and have no knowledge/limited knowledge of your ancestry/ethnicity and family history.

❑Myself ❑My Partner ❑Not Applicable

In this or any previous relationship, have you or your partner had a pregnancy diagnosed with a chromosomal disorder (e.g. Down syndrome) or birth defects? If yes, please specify the diagnosis:

❑Myself ❑My Partner ❑Not Applicable

Diagnosis: _____

Have you or your partner had any genetic carrier screening? If yes, please list which test was performed and the results. *(When submitting your paperwork, be sure to include a copy of these reports, if possible)*

❑Myself ❑My Partner ❑Not Applicable

Testing performed: _____

Please indicate your ancestry/ethnicity (mark all that apply):

Ethnicity	Patient	Partner
African American		
Caucasian		
Eastern European (Ashkenazi) Jewish		
French Canadian or Cajun		
Hispanic		
Italy, Greece, or the Middle East		
Native American		
Pacific Islander		
Asian		

Are you and your partner related in any way (e.g. cousins)? ❑Yes ❑No

If yes, please describe the relation: _____

Does/did anyone in either your or your partner's family have any of the following?
Please include yourself, your partner, your children, parents, siblings, nieces & nephews, aunts & uncles, first cousins, and grandparents:

After reviewing the below, none of the listed conditions apply ❑ Initials:			
	Yes	**No**	**If yes, specify <u>what</u> and <u>who</u>**
Cystic Fibrosis	❑	❑	
Blood disorders or bleeding disorders (e.g. Sickle Cell Anemia, Hemophilia, Thalassemia)	❑	❑	
Chromosomal abnormalities, Translocation disorders	❑	❑	
Muscle or neurological disease (e.g. Muscular or myotonic dystrophy, Spinal Muscular Atrophy, Neurofibromatosis, Huntington disease)	❑	❑	
Skeletal dysplasia/dwarfism	❑	❑	
Intellectual disability/developmental disability, Autism	❑	❑	
Fragile X syndrome	❑	❑	
Deafness/Early Onset Hearing Loss	❑	❑	
Blindness/Early Onset Vision Loss	❑	❑	
Two or more miscarriages and/or still births	❑	❑	
Premature menopause before age 40	❑	❑	
Any known fertility issues	❑	❑	
Hereditary cancer syndrome or cancer diagnosed < age 50	❑	❑	

Please use this space for additional details about your answers above or to let us know of any additional family history concerns that you would like to discuss with your provider:

_____

_____

❑ I am interested in meeting with a genetic counselor regarding the above information. *Your provider will discuss this process at your visit.*

❑ I am not interested in genetic counseling at this time. If I change my mind, it is my responsibility to contact my provider to request counseling. I also understand that, by declining these counseling services, I may be missing an opportunity to identify my risk of having a child affected with a genetic condition.

Patient signature: _____Today's date: _____

FOR OFFICE USE ONLY
❑ Genetic counseling was recommended with the genetic counselor at The Fertility Center. ❑Accepted; ❑ Declined
❑ Genetic counseling was recommended with: _____. ❑Accepted; ❑Declined
❑ All questions were answered. No genetic counseling is recommended at this time.

Physician signature: _____Date:_____

Questions for your TFC Physician

We understand that this process can be overwhelming. You have so many thoughts and questions running through your mind that it's easy to forget to ask some of the big things you were hoping to have answered.

In an effort to prevent that from happening and making the best use of your time at your new patient appointment, we wanted to provide a space for you to compile your thoughts and questions while you have the time to think it through thoughtfully.

This form is for your use only. You do not need to return this with your new patient paperwork.