MID-SOUTH MATERNAL FETAL MEDICINE, P.C.

CYSTIC FIBROSIS CARRIER SCREENING

Cystic Fibrosis (CF) is an inherited genetic condition. The symptoms of CF can vary greatly, although the majority of affected individuals have problems with their lungs and digestion. Treatments for CF have greatly improved over the last decade, resulting in an increase in the average life span of persons with CF to approximately age 30.

Cystic Fibrosis is a recessive genetic condition, which means that both parents must be CF carriers in order to have a child with CF. A CF carrier is someone who has a change in one of their CF genes. About 1 in every 29 Caucasians carries a change in the gene for cystic fibrosis. People of other ethnic backgrounds may also be carriers of CF. Hispanics have a 1/46 risk to be a CF carrier, for African-Americans the carrier risk is about 1/60, while Asian populations have a risk of about 1/90. If BOTH parents in a couple are found to be carriers of CF then that couple would have a 25% or 1 in 4 chance with each pregnancy of having a child with CF.

If you do not have a family history of CF, then your chances to have a baby with CF would be as follows:

- Both parents Caucasian: 1 chance in 3,600
- Both parents Hispanic: 1 chance in 8,500
- Both parents African American: 1 chance in 14,400
- Both parents Asian: 1 chance in 32,400

A family history of CF increases the chances of having a child with CF.

Cystic Fibrosis carrier screening is a blood test. CF screening is available for all individuals who are pregnant or planning a pregnancy to determine if either parent is a carrier of CF. DNA testing for CF detects approximately 80-90% of Caucasian carriers, approximately 95-97% of Ashkenazi Jewish carriers, approximately 60% of African-American and Hispanic carriers and approximately 30-40% of Asian carriers. Therefore, even if neither member of a couple is found to have a common mutation there is still some risk.

Would you like the doctor or genetic counselor to discuss this issue during your appointment?

_____ Yes, please have the doctor or genetic counselor discuss this issue with me.

_____ No, I am not interested in further discussion of cystic fibrosis (CF) carrier testing.

_____ _____

Signature Date

GENETIC COUNSELING INFORMATION SHEET

Please complete the following information on you, your family and the father of the baby and his family. Try to answer all questions completely and accurately. If you need more room, write on back of page.

Patient Information

Last Name		First Name	MI	Maiden Name	
Race	Religion	Birth Date	Occupation		
Home Address					
City			State	Zip	
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Separated	

Patient Current Medical History

When was your last menstrual period? _____ _

What is your due date: _____

Have you had an ultrasound during this pregnancy? ..... ☐ Yes ☐ No

Have you had a fever during this pregnancy? ..... ☐ Yes ☐ No

Have you had diabetes prior to or during this pregnancy? ..... ☐ Yes ☐ No

Have you consumed any alcohol during this pregnancy? ..... ☐ Yes ☐ No

Do you smoke? ..... ☐ Yes ☐ No

If yes, how many per day? _____

Have you taken any medications during this pregnancy? ..... ☐ Yes ☐ No

If yes, please list:

Have you had any complications with this pregnancy? ..... ☐ Yes ☐ No

If yes, please explain: _____

Have you had any miscarriages? ..... ☐ Yes ☐ No

If yes, please list dates: _____

When the results of the chromosome studies are given, do you want to know the sex of the fetus? ☐ Yes ☐ No

Referring Physician Information

Physician's Full Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

PATIENT FAMILY HISTORY

Please list all of your children in order of birth; indicate if child or stepchild.

FULL NAME AGE STATE OF HEALTH Brother/Sister/Half Bro-Sis

_____

_____

_____

Is your mother living? □ Yes □ No What is her current age/was her age at death? _____

How many brothers/sisters did your mother have? Brothers _____ Sisters _____

Is your father living? □ Yes □ No What is his current age/was his age at death? _____

How many brothers/sisters did your father have? Brothers _____ Sisters _____

Please list all of your siblings in order of birth; indicate if brother, sister, half-brother or half-sister.

FULL NAME AGE STATE OF HEALTH Brother/Sister/Half Bro-Sis

_____

_____

_____

_____

INFORMATION ABOUT THE FATHER OF THE BABY

Last Name: _____ First Name: _____

Age: _____ Religion: _____ Race: _____ Occupation: _____

Home Phone: _____ Work Phone: _____

Is his mother living? □ Yes □ No What is her current age/was her age at death? _____

How many brothers/sisters did his mother have? Brothers _____ Sisters _____

Is his father living? □ Yes □ No What is his current age/was his age at death? _____

How many brothers/sisters did his father have? Brothers _____ Sisters _____

Please list the father's siblings in order of birth; indicate if brother, sister, half-brother or half-sister.

FULL NAME AGE STATE OF HEALTH Brother/Sister/Half Bro-Sis

_____

_____

_____

MATERNAL PRENATAL SCREEN

(THESE QUESTIONS TO BE ANSWERED BY PATIENT ONLY)

NAME _____SOC. SEC.# _____DATE _____

Will you be 35 years or older when the baby is due? ..... ☐ Yes ☐ No

Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

Down Syndrome (mongolism) ……... ☐ Yes ☐ No

Other chromosomal abnormality …… ☐ Yes ☐ No

Neural tube defect, i.e. spina bifida (meningomyelocele or open spine), anecephaly …….. ☐ Yes ☐ No

Hemophilia ……..... ☐ Yes ☐ No

Muscular Dystrophy ……... ☐ Yes ☐ No

Cystic Fibrosis …… ☐ Yes ☐ No

If yes, indicate the relationship of the affected person to you or to the baby's father: _____

_____

Do you or the baby's father have a birth defect? ……. ☐ Yes ☐ No

If yes, who has the defect and what is it? _____

In any previous marriages, have you or the baby's father had a child with a birth defect not listed in the question above? …….. ☐ Yes ☐ No

If yes, what is the defect and who had it? _____

Do you or the baby's father have any close relatives with mental retardation? ……. ☐ Yes ☐ No

If yes, indicate the relationship of the affected person to you or to the baby's father. Indicate the cause, if known: _____

Do you, the baby's father, or a close relative in either of your families have a birth defect, familial disorder, or a chromosomal abnormality not listed above? ……. ☐ Yes ☐ No

If yes, indicate the condition and the relationship of the affected person to your or to the baby's father: _____

In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester pregnancy losses? …….. ☐ Yes ☐ No

If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? …… ☐ Yes ☐ No

If yes, indicate who and the results:

If you or the baby's father are black, have either of you been screened for sickle cell trait? …… ☐ Yes ☐ No

If you or the baby's father are of Italian, Greek or Mediterranean background, have either of you been tested for B-thalassemia? …….. ☐ Yes ☐ No

If yes, indicate who and the results:

If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for a-thalassemia? ……... ☐ Yes ☐ No

If yes, indicate who and the results:

Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include non-prescription drugs) …….. ☐ Yes ☐ No

If yes, give name of medication and time taken during pregnancy: _____