Pregnancy Medication List

COLD,FLU and COUGH	UNDER 12 WEEKS	OVER 12 WEEKS
Triaminic	NO	YES
Tylenol	YES	YES
Sudafed	YES	YES
Actifed (only if Sudafed doesn't work)	NO	YES
Robitussin Plain or DM	YES	YES
Afrin or Neosporin nasal spray	YES	YES
Throat lozenges or sprays	YES	YES
Cough Drops	YES	YES
Benadryl	NO	YES
Aspirin	NO	NO
Ibuprofen	NO	NO
DIARRHEA		
Kaopectate	YES (24 Hrs only)	YES
Imodium AD	YES (24 Hrs only)	YES
CONSTIPATION		
Metamucil	YES	YES
Citrucel	YES	YES
Colace	YES	YES
INDIGESTION/HEARTBURN		
Maalox	YES	YES
Mylanta	YES	YES
TUMS (low sodium)	YES	YES
Tagament, Pepcid, Zantac (only if liquids don't work)	NO	YES
NAUSEA/VOMITING		
Vitamin B6 (100mg tab, 1 tab daily)	YES	YES
Emetrol (OTC)	YES	YES
RASHES		
Hydrocortisone (topical)	YES	YES
Calacryl	YES	YES
MISCELLANEOUS		
Tetanus Toxoid	YES	YES
TB Skin Test	YES	YES
Xylocain/Lidocaine (for local anesthetic)	YES	YES
Flu shot/ H1N1 vaccine	YES	YES

Special Testing & Screenings

HIV (Human Immunodeficiency Virus)

It is recommended by the American College of Obstetricians and Gynecology and the American Pediatrics Association that all pregnant women be offered testing for HIV early in pregnancy.

If mother is positive, she has a 30% chance of transmitting the disease to the baby prior to the birth. HIV infection acquired during the pregnancy causes almost all cases of HIV in children.

With the appropriate HIV treatment, transmission of HIV from mother to baby is reduced to 1%.

CF (Cystic Fibrosis)

Cystic Fibrosis is one of the most common inherited diseases in the Caucasian population. It is caused by failure of a protein that maintains the chloride (salt) balance in the body. CF causes the body to produce thick mucus that can cause breathing problems and lung infections, digestive problems (difficulty absorbing some types of foods), and infertility. CF does not cause mental retardation or birth defects.

The symptoms of CF vary from person to person. Some health problems caused by CF can be treated, but the disease itself cannot be cured. Most people with CF have a shortened life span; some will not survive past childhood, but others will live into their 40s or longer.

CF testing is not required; it is an option. Choosing CF carrier screening is a personal choice that should be discussed with a health care provider or genetic counselor.

Birth Defects

Screening tests can give information about a pregnant women's risk of having a baby with certain birth defects or genetic conditions. These tests also can help your doctor detect possible problems during your pregnancy. Some pregnant women may have other tests, depending on their medical histories, previous pregnancies, family or ethnic background, or exam results.

1st Trimester (11-14 wks): Ultrascreen-Down Syndrome and Trisomy 18.

2nd Trimester : AFP– Down syndrome, trisomy 18, and neural tube defects.

Associates in Central Ohio Obstetrics and Gynecology, Inc.

acoog-obgyn.com

CONGRATULATIONS!!

Your initial obstetrical appointment is scheduled for:

Date: ______________________

Time: ______________________

With: ______________________

Office Location

575 Westar Crossing, Suite 102
Westerville, OH 43082
Ph: (614) 839-5555
Fax: (614) 839-5100

7235 Sawmill Rd., Suite 200
Dublin, OH 43016
Ph: (614) 889-6117
Fax: (614) 889-8099

6482 East Main Street, Suite B
Reynoldsburg, OH 43068
Ph: (614) 856-0327
Fax: (614) 856-3300

Physicians

Joseph F. Amato MD
Karen D. D'Angelo MD
Susan M. Davy MD
Amy K. Jackson MD
Beth Lafont MD
Susan L. Vagnier MD

Important Information

Our office consists of both male and female physicians. The physicians rotate taking call therefore care may be rendered by both.

Our office also has a male ultrasonographer who may be asked to scan you throughout your pregnancy.

Our physicians perform deliveries at the following hospitals only:

St. Ann's Hospital
500 Cleveland Ave
Westerville, OH 43081

Riverside Hospital
3535 Olentangy River Road
Columbus, OH 43214

All our doctors share weekend and evening call coverage.

The initial OB office visit

Because of the physical exam, please do not douche or have intercourse 24 hours prior to your appointment. The visit will consist of an interview, physical examination, blood work, and an ultrasound. Please allow 1 1/2 hours for your initial visit, even if you have been seen at our practice previously for a pregnancy.

Insurance

If your insurance carrier requires a referral from your primary care physician, it is your responsibility to obtain this referral prior to the date of your office visit. It is advisable for you to call our office prior to your visit to verify that we received your referral. If you do not have the proper referral by the time of your appointment, you will be asked to reschedule your appointment.

Your insurance company will be contacted by the practice for verification of your maternity benefits. Our office **does require** payment of any deductibles, copayments or uninsured portion of services in full by your seventh month of pregnancy. Once this information is obtained from your insurance carrier you will be set up on a monthly payment schedule for your patient responsibility.

Information required prior to being seen

We require that you present your insurance card at every visit. If you had an insurance change and have not yet received your card from your insurance carrier, we ask that you contact our office prior to your appointment so that we may advise you of the information required to be see.

If you do not have insurance to cover the obstetrical fees, you are required to pay in full for your initial visit. A payment plan will be implemented for the remaining balance of your prenatal care and delivery. Our office policy requires the entire amount to be paid in full by your seventh month of pregnancy. You must make monthly payments towards your balance. We accept the following methods of payment:

- Cash
- Check
- Credit card: Visa, Mastercard, and Discover

All paperwork must be filled out completely.

- You must have your insurance card and co-pay at your appointment.
- You must arrive on time for your appointment. Arrive approximately 15 minutes prior to your appointment time if you have a change of address, insurance, or employment in order to update this information.
- We require 24 hours notice if you need to cancel or reschedule your appointment. Failure to do so will result in a **no show charge** to be applied to your account. This is a $52.00 charge.

If you have any questions or concerns please contact us at the appropriate office.

Billing Department:
(614) 923-0153

Morning Sickness

Nausea and vomiting may occur during the early months of pregnancy. Although it's frequently called "morning sickness", it can occur any time of day or night. Usually it disappears after the third month of pregnancy.

Morning sickness is the result of increased amounts of estrogen and progesterone which are produced by the ovaries early in pregnancy. Due to the increased levels of these hormones, the secretory cells in the stomach increase their production of gastric juices. At the same time, the bowel slows down in it's ability to empty the contents of the stomach. This then causes a feeling of nausea, and in some cases, vomiting.

Prevention & Treatment for Morning

Eat a piece of bread or a few crackers before you get out of bed in the morning or when you feel nauseated.

Get out of bed slowly. Avoid sudden movements.

Have some yogurt, cottage cheese, juice, or milk before you get up.

Eat several small meals during the day so that your stomach doesn't remain empty for a long period of time.

Eat high protein foods such as eggs, cheese, nuts, meat, as well as fruits and fruit juices. These foods help prevent low levels of sugar in your blood, which can also cause nausea.

Sip carbonated beverages when you begin to feel nauseated.

Get fresh air. For example, take a walk, sleep with the window open, use an exhaust fan or open a window when cooking.

Take deep breaths. In through your nose and out through your mouth.

Drink spearmint, peppermint, raspberry leaf, ginger root tea, or ginger ale. Eat fresh ginger root.

Associates in Central Ohio OB/GYN, Inc.

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6482 East Main Street, Suite B, Reynoldsburg, OH 43068 (614) 856-0327
7235 Sawmill Road, Suite 200, Dublin, OH 43016 (614) 889-6117

This section for office use.
☐ New patient ☐ Established patient Abstractor: ________________ Date: ____/____/______

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status

**Can we confirm your appointment via email? YES NO Primary Care Physician: ______________________

Social Security Number: _____ - _____ - _______ Date of Birth: _____ / _____ / _______

Emergency Contact

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ Other

Other (Please Specify): ______________________________ Effective Date: _____ / _____ / ______

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (______) ______ - _________
Social Security Number of Policy Holder: ______ - ______ - ________ Policy Holder Date of Birth: ______/________/________
Insurance Identification Number: ________________ Group Identification Number: ________________

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: ________________

Name of Employer (Company Name) Occupation

Phone Number: (____) _____ - ________
Address

City State Zip Code

Patient Name: ______________________________

Confidential Communications

I hereby request to receive confidential communication from ACOOG in the following manner:

1. Telecommunications/E-mail:
   - ☐ Web enable this account using ACOOG's patient portal.

   Please leave messages as follows (check all that apply):
   - ☐ Home Phone **Brief or Extended** ☐ Cell Phone **Brief or Extended**
   - ☐ Work Phone **Brief or Extended**
2. Postal Communications:

   Please mail my protected health information to me at (select only one):
   - ☐ Mailing Address on file ☐ Other as follows

   Address:______________________ City:______________ State:_____ Zip:_______
3. Emergency contact as listed on page one (1) of this form
4. Additional Contact (optional)

   Name:______________________ Relation:______________ Phone # ______________

Notice of Privacy Practices

I understand ACOOG will notify me if ACOOG is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency situation. I have received the Notice of Privacy Practices at Associates in Central Ohio OB/GYN, Inc. (ACOOG). ☐ **Yes** ☐ **No** **Initials** __________

Insurance Assignment and Acknowledgement:

I understand my insurance carrier can choose to assign benefits to Associates in Central Ohio OB/GYN, Inc. or my insurance carrier may make payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly by me insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my defendants. I am also responsible for providing up-to-date and accurate insurance information for each visit. We file claims directly to primary insurance only (exception: secondary government plans). Upon request we will provide a claim form for you to file with your secondary insurance carrier. If you are required to have a referral for your appointment, please be sure to bring it to your appointment.

If we are not participants in your insurance plan, upon request, our billing office will provide you with an itemized claim form to file with your insurance carrier for reimbursement. However, payment is expected in full at time of service. ***Billing#614-923-0153.***

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder for medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

We require a 24 hour cancellation notice. Failure to due so will result in a $52 no show fee after first occurrence. If you fail to make payment in full for services rendered to you, your outstanding balance will be placed with our collection attorney.

By signing below, I certify I will pay to Associates in Central Ohio OB/GYN, Inc. any co-payments, co-insurance, deductibles or non-covered services. I understand the ACOOG does not accept post-dated checks. I will immediately pay to Associates in Central Ohio OB/GYN, Inc. any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide that appropriate insurance information for billing.

______________________	______________________	______________
Patient Printed Name (if 18 and older)	Patient Signature (if 18 or older)	Date Signed

______________________	______________________	______________
Guarantor Printed Name (if applicable)	Guarantor Signature (if applicable)	Date Signed

Medications

List all medications you take, prescription and nonprescription, and their dosage:

☐ No medications

	Medication	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medication Allergies

Please list medications that you are allergic to and/or check any of the following foods:

	Medication/Food	Reaction	Medication/Food	Reaction
1				
2				
3				
4				

Do you have a Latex Allergy? YES NO

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

Condition	Date	Condition	Date	Condition	Date
☐ Alcohol dependence	___/___/___	☐ Diabetes Type I	___/___/___	☐ Kidney stones	___/___/___
☐ Allergies	___/___/___	☐ Diabetes Type II	___/___/___	☐ Kidney disease	___/___/___
☐ Anxiety	___/___/___	☐ Diarrhea	___/___/___	☐ Liver disease	___/___/___
☐ Arthritis	___/___/___	☐ Disc degeneration	___/___/___	☐ Migraines	___/___/___
☐ Asthma	___/___/___	☐ Drug Dependence	___/___/___	☐ Obesity	___/___/___
☐ Blood clots	___/___/___	☐ Emphysema	___/___/___	☐ Osteoarthritis	___/___/___
☐ Broken bones	___/___/___	☐ GERD	___/___/___	☐ Osteoporosis	___/___/___
☐ Bronchitis	___/___/___	☐ Gallbladder stones	___/___/___	☐ Rheumatoid Arthritis	___/___/___
☐ Cancer	___/___/___	☐ Goiter	___/___/___	☐ Sciatica	___/___/___
Type: ____________	____________	☐ Heart attack	___/___/___	☐ Seizures/epilepsy	___/___/___
________________________		☐ Heart disease	___/___/___	☐ Sinusitis	___/___/___
☐ Chronic fatigue syndrome	___/___/___	☐ Hepatitis	___/___/___	☐ Sleep apnea	___/___/___
☐ Circulatory disease	___/___/___	☐ High blood pressure	___/___/___	☐ STD ____________	___/___/___
☐ Colitis	___/___/___	☐ High cholesterol	___/___/___	☐ Stomach ulcer	___/___/___
☐ COPD	___/___/___	☐ Insomnia	___/___/___	☐ Stroke (CVA)	___/___/___
☐ Crohn's disease	___/___/___	☐ Irregular heart rhythm	___/___/___	☐ Thyroid disease	___/___/___
☐ Depression	___/___/___	☐ Irritable bowel (IBS)	___/___/___	☐ Tuberculosis	___/___/___

Health Maintenance

Exams	Date of Last	Results	Vaccines	Date of Vaccine
Bone Density			Flu Vaccine	
Breast Exam			Tetanus Vaccine (Tdap)	
Colonoscopy			HPV (Gardasil) #1	
Gyn Exam			HPV (Gardasil) #2	
Mammogram			HPV (Gardasil) #3	
Pap Smear			TB Screen	
Other			Other	

Obstetrical History:

How many times have you been pregnant? (Include miscarriages, abortions, etc.) ____________

How many children have you given birth to? ____________

Date	Sex	Weight	Weeks at Delivery	Labor Length	Delivery Type	Complications

Surgical History

Date	Surgery Type	Dr.'s Name	Hospital

DELIVERING HOSPITAL: ST. ANN'S RIVERSIDE UNDECIDED

Pre-Pregnancy Weight: ____________

BREAST BOTTLE BOTH UNDECIDED

Do you plan on attending childbirth classes? YES NO UNDECIDED

Do you have cats in your home: YES NO

Have you had chicken pox? YES NO

Ok with transfusion if needed? YES NO

Father of Baby First Name: ____________ Phone Number: ____________ Ok to call: Y N

Father if Baby Ethnicity: ____________

Menses:

Last Menstrual Period ______/______/______ Menses Monthly: YES NO

Frequency (days between periods):______ Last period: definite unknown approximate (month known)

Normal Amount/Normal duration YES NO

Were you on Birth Control? YES NO

When did you have your positive home pregnancy test? ______/______/______

At what age did you start your periods? ______

REVIEW OF SYMPTOMS (Circle all that apply) No associated symptoms

Anorexia
Bleeding
Breast Tenderness
Constipation
Edema (Swelling)
Fatigue
Fever
Headache
Heartburn
Irritability
Nausea
Pelvic Pain
Spotting
Urinary difficulty
Vaginal Discharge
Vomiting

Additional Concerns ____________

Family History

Please check if any family members have had any of the following conditions. Indicate the affected member, the age of onset and/or if it was the cause of death.

☐ ADOPTED

Condition	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
☐ ADD/ADHD						
☐ Alcoholism						
☐ Alzheimer's disease						
☐ Asthma						
☐ Blood Clots						
☐ Heart disease/Heart Attack						
☐ Heart disease before age 50						
☐ Cancer						
Type: ______						
☐ Depression						
☐ Developmental delay						
☐ Diabetes						
☐ High cholesterol						
☐ High Blood Pressure						
☐ Inflammatory Bowel Disease						
☐ Kidney disease						
☐ Liver Disease						
☐ Mental illness						
☐ Migraines						
☐ Obesity						
☐ Osteoporosis						
☐ Seizures/epilepsy						
☐ Stroke (CVA)						
☐ Thyroid Disorder						
☐ Other:						

☐ Family History of: ______

Social History

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? ______/______

Packs per day? ______ Years smoked? ______ Year Quit? ______

Other Tobacco units per day (cans, cigars, etc)? ______

Units per day? ______ Years used______? Year Quit? ______

Do you drink caffeine? ☐ Yes ☐ No Type? ______ Amount Daily? ______

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Year Quit? ______

Type? ______ How much per week? ______

Amount? ______ Last Drink? ______

Do you or have you used illegal Drugs: ☐ Yes ☐ No Type? ______ Amount Daily? ______

Years Used: ______ Year Quit: ______

Marital Status: Single Married Divorced Separated Widow Other

Sexual Preference: Heterosexual Homosexual Bisexual

Previous Blood Transfusion: Yes No If Yes, Year ______

Any History of Sexual Abuse: Yes No

Any History of Domestic Violence: Yes No

Religious Preference: ______ **Ethnicity:** ______

Do you have a preferred pharmacy? ☐ Yes ☐ No

Pharmacy: ______ Phone Number: ______

Address: ______

Pharmacy: ______ Phone Number: ______

Address: ______

Associates in Central Ohio Obstetrics and Gynecology, INC

575 Westar Crossing, Suite B • Westerville, OH 43082 • (614) 839-5555
6482 East Main Street, Suite B • Reynoldsburg, OH 43068 • (614) 856-0327
7235 Sawmill Road, Suite 200 • Dublin, OH 43016 • (614) 889-6117

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact the Privacy Officer at (614) 839-5555.
Effective date of the Notice: **April 28, 2015**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Source: U.S. Department of Health & Human Services

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes

Applicable State and Other Laws

Electronic Access

Associates in Central Ohio provides electronic access to your health information via Patient Privilege.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Source: U.S. Department of Health & Human Services

OBSTETRICAL ULTRASOUND

I, ______________________________, hereby request the performance of an **Obstetrical Ultrasound**. This procedure will be preformed by ____________________________________.

Ultrasound is a technique used to view the baby in the uterus (womb) with the use of sound waves. During an abdominal ultrasound examination, a gel is spread over your abdomen and a scanning device moves lightly over the area. As sound waves pass through the layers of the abdomen and uterus, they are reflected to show the developing baby, placenta, uterus, and nearby structures. These images are then converted into sound echoes, which can be seen on a monitor. In the case of vaginal ultrasound, performed in early pregnancy or in certain other situations, the scanning device is a small probe, which is placed inside the vagina. This is similar to having a pelvic examination and may be mildly uncomfortable.

This ultrasound test is not a treatment for any condition but is done for diagnostic purposes. The information obtained may be used to confirm the presence of fetal heart beat, evaluate the baby's growth, estimate the size of the baby, detect the presence of multiple fetuses, **and to detect some but not all birth defects**. It is possible that fetal birth detects may not be seen on the ultrasound examination performed today, or that anatomy could falsely appear abnormal. Therefore, neither a normal ultrasound nor the results of any prenatal test guarantee a normal, healthy baby.

Currently, there are no known health risks to the mother or fetus during an ultrasound examination.

There may be alternatives to this examination available to you. However, alternative methods of prenatal diagnosis have their own risks.

I acknowledge that I have had an opportunity to discuss with and have had explained to my satisfaction the purpose and nature of this obstetrical ultrasound, as well as reasonable risks. I understand that medicine is not an exact science, that it may involve the making of medical judgments based upon the facts known to the physician at the time, and that it is not reasonable to expect the physician to be able to anticipate or explain all possible risks and complications, and further, that an undesirable result does not necessarily indicate an error in judgment. I understand that no guarantee as to the results have been made to me. I expressly wish the physician to exercise his/her best judgment during the course of the procedure, and to inform me of the findings of the obstetrical ultrasound.

I DO or DO NOT wish to know the estimated gender of my baby. (Please circle one)

I understand that there is not 100% certainty when determining gender through ultrasound.

I understand that this obstetrical ultrasound may or may not be paid for by my insurance company. Many insurance companies will not pay for an ultrasound unless medical indications are present. I understand and agree that if the procedure is not paid for by my insurance, I will be responsible for the payment.

All my questions have been answered, and I do herby consent to the performance of an obstetrical ultrasound.

______________________________ ______________________________

(Patient Signature) (Printed Patient Name)

______________________________ ______________________________

(Physician/Provider Signature) (Date)

Infection History

	Circle Yes Or No	
1 Do you live with someone or been exposed to TB?	Yes	NO
2 Do you have or have you been exposed to genital herpes?	Yes	NO
3 Have you had a rash or viral illness since last period?	Yes	NO
4 Do you have or have you been exposed to Hepatitis B or C?	Yes	NO
5 Do you have a history of the following:		
Sexually Transmitted Disease?	Yes	NO
Gonorrhea?	Yes	NO
Chlamydia?	Yes	NO
HPV/Genital Warts?	Yes	NO
HIV?	Yes	NO
Syphillis?	Yes	NO
6 Other?	Yes	NO

Genetic Screening/Teratology Counseling

	Circle Yes or No		Mother (patient)	Father (baby's)	Relative (mother or father)
1 Will you be 35 years or older when the baby is due?	Yes	No			
2 Have you ever been tested for Thalassemia? (Italian, Greek, Asian or Mediterranean background)?	Yes	No			
3 History of Neural tube defects? (Spina bifida, anencephaly or meningomyelocele)?	Yes	No			
4 Congenital Heart Defect?	Yes	No			
5 Down Syndrome?	Yes	No			
6 Tay-sachs (Ashkenazi Jewish, Cajun, French Canadian)?	Yes	No			
7 Canavan disease (Ashkenazi Jewish)?	Yes	No			
8 Familial dysautonomia (Ashkenazi Jewish)?	Yes	No			
9 Sickle cell disease or trait (Black/African)?	Yes	No			
10 Hemophilia or other blood disorders?	Yes	No			
11 Muscular dystrophy?	Yes	No			
12 Cystic Fibrosis (CF)?	Yes	No			
13 Huntington's chorea?	Yes	No			
14 Mental Retardation/Autism?	Yes	No			
15 Other inherited genetic or chromosomal disorder?	Yes	No			
16 Maternal metabolic disorder (Diabetes, PKU, etc.)?	Yes	No			
17 Do you or the baby's father have a child with birth defects not listed above?	Yes	No			
18 Have you had recurrent pregnancy loss or stillborn?	Yes	No			
19 Medications (including supplements, vitamins, herbs or OTC drugs/illicit or recreational drugs or alcohol since LMP?	Yes	No			
20 Any other:	Yes	No			

Race: (Circle) White/Caucasian Black/African American Hispanic Asian American Indian Other ____________

Associates in Central Ohio OB/GYN, INC

575 Westar Crossing, Suite 102 • Westerville, OH 43082 • (614) 839-5555
6482 East Main Street, Suite B • Reynoldsburg, OH 43068 • (614) 856-0327
7235 Sawmill Road, Suite 200 • Dublin, OH 43016 • (614) 889-6117

CONSENT FOR CYSTIC FIBROSIS TESTING

I HAVE RECEIVED INFORMATION ON CYSTIC FIBROSIS TESTING AND UNDERSTAND THE MATERIAL. I HAVE ALSO DISCUSSED THE TEST WITH MY PHYSICIAN.

I WISH TO BE TESTED FOR CYSTIC FIBROSIS

SIGNATURE ______________________________________ DATE ___________

I **DO NOT** WISH TO BE TESTED FOR CYSTIC FIBROSIS

SIGNATURE ______________________________________ DATE ___________

HIV testing

National guidelines require that every pregnant patient be tested for HIV with each pregnancy. If your HIV status is not listed on the chart, the physician that will be evaluating your newborn will need to draw an HIV test on him or her. The state of Ohio requires that we offer you the option of "anonymous" testing instead of drawing it here in our office today. You will need to ask your baby's pediatrician if he or she will accept this as a valid test. If you wish to have anonymous testing done, we can provide a list of places where you can receive such testing.

I, ______________________________ (print your name) agree to having my HIV test completed here at ACOOG. I understand that this is not an anonymous test.

______________________________ ________________

Signature Date

I, ______________________________ (print your name) decline testing here at ACOOG. I will pursue anonymous testing. I understand that I am responsible to have the results available for the immediate postpartum evaluation of my child.

______________________________ ________________

Signature Date

You are your baby's protector.
Choose caregivers wisely.

Even when you aren't with your baby, you are responsible for your baby's safety.

Before leaving your baby with anyone, ask these questions:

- Does this person want to watch my baby?
- Have I had a chance to watch this person with my baby before I leave?
- Is this person good with babies?
- Has this person been a good caregiver to other babies?
- Will my baby be in a safe place with this person?
- Have I told this person to never shake my baby?

Trust your instinct. If it doesn't feel right, don't leave your baby!

Do not leave your baby with anyone who:

- Is impatient or annoyed when your baby cries.
- Says your baby cries too much.
- Will become angry if your baby cries or bothers them.
- Might treat your baby roughly because they are angry with you.
- Has a history of violence.
- Has lost custody of their own children because they could not care for them.
- Abuses drugs or alcohol.

Tell anyone who cares for your baby to call you any time they become frustrated.
Tell them not to shake your baby.

Has Your Baby Been Shaken?

Call 911.

All of these signs are very serious:

- Limp, like a rag doll.
- Poor sucking and swallowing.
- Trouble breathing.
- Unable to waken.
- Irritability or crankiness.
- Seizures or trembling.
- Vomiting.
- Skin looks blue or feels cold.

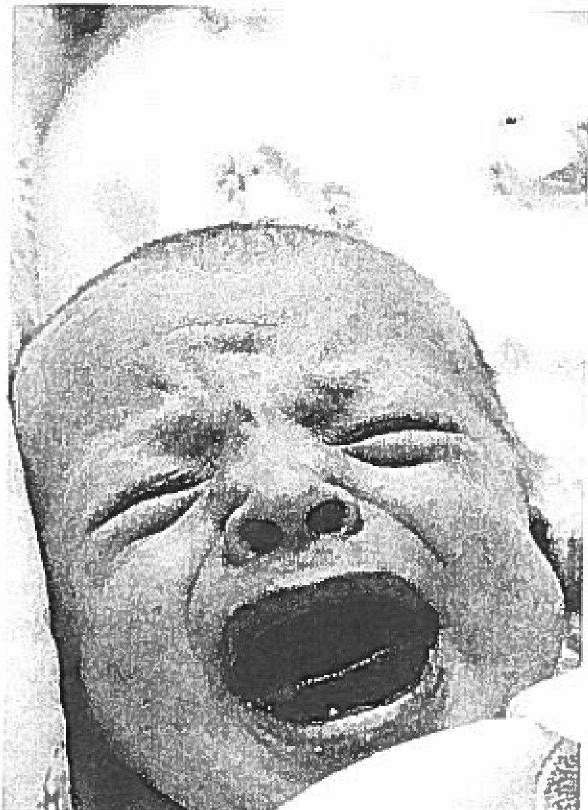
Save precious time! If you think your baby has been shaken, tell the doctors right away!

For more help coping with a crying baby:

1-800-755-GROW

Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
http:www.odh.ohio.gov

Babies cry a lot.



It's normal.

Learn more and have a plan.

Keep your baby safe!

All babies cry.

It is normal and natural. Healthy babies start crying the day they are born. Crying increases when babies are 2 weeks old, and gets worse at 2 months old. Babies cry more in the afternoon or evening. Babies can cry 2 to 3 hours a day, for an hour at a time! It is normal.

Crying is the only way your baby can communicate. Your baby cries to tell you he:

- Is hungry.
- Needs to be burped.
- Needs a diaper change.
- Is too hot or too cold.
- Is lonely or scared.
- Is in pain or uncomfortable.
- Is over-tired or over-stimulated.

Sometimes, parents and caregivers can't figure out why a baby is crying.

Toddlers cry, too.

Toddlers cry for the same reasons babies cry. Plus, toddlers cry when they try to learn new things. Toddlers and their crying can be especially frustrating at times such as:

- Potty training.
- Feeding time.
- Naptime and bedtime.
- When teething.

Tips for soothing crying babies.

Because all babies cry, try not to let the crying frustrate you. Check for the common reasons for crying, then try some of the following:

- Hold the baby close and walk or gently rock. Wrap the baby snugly in a soft blanket.
- Find a calm, quiet place. Turn out the lights; turn off loud music and the TV.
- Offer a pacifier.
- Take the baby for a ride in a stroller or car. Always use a car seat.
- Play soft music; hum or sing to the baby.
- Run the vacuum, dryer, dishwasher or fan to make background noise.
- Place the baby in a baby swing.
- Lay the baby across your lap and gently rub or tap the baby's back.
- If all else fails, place the baby on her back in a safe crib or playpen. Walk away and check back every 5 to 10 minutes.
- Call your baby's doctor or nurse if your baby seems sick.
- If you feel you are getting stressed out, call a trusted friend or relative for help.

Sometimes, a crying baby just can't be soothed. It is OK to ask for help.

Never shake your baby!

No matter how long your baby cries or how frustrated you feel, never shake or hit your baby.

Shaking can cause brain damage that can lead to:

- Blindness
- Epilepsy (seizures)
- Mental retardation
- Behavior problems
- Death
- Deafness
- Cerebral palsy
- Learning problems
- Poor coordination

Shaken baby syndrome is a brain injury that happens when a frustrated person violently shakes a baby or toddler.

Calm yourself, so you can calm your baby safely.

Caring for babies and toddlers is stressful, even when they are not crying. Know when you are becoming stressed out. Have a plan to calm yourself. **After putting your baby on his back in a safe crib or playpen:**

- Take several deep breaths and count to 100. Go outside for fresh air.
- Wash your face, or take a shower.
- Exercise. Do sit-ups, or climb the stairs a few times.
- Go in another room and turn on the TV or radio.
- Call a friend or relative.

Check on your baby every 5 to 10 minutes.

Most adults feel frustrated when babies and toddlers cry.

STATE OF OHIO

Ohio Department of Health

SHAKEN BABY SYNDROME PROGRAM

As the proud parent of

____

I KNOW: It is my job to keep my baby safe.

I KNOW: Crying is normal. Babies cry 2 to 3 hours a day. Crying can last an hour at a time. Babies cry more often in the afternoon and evening. Crying increases when babies are 2 weeks old, and gets worse at 2 months old.

I KNOW: Caring for a crying baby can be frustrating. Sometimes, even the best parents and caregivers cannot figure out why a baby is crying. Sometimes, even the best parents and caregivers cannot soothe a crying baby.

I KNOW: Shaking can seriously injure or kill my baby. Instead of shaking, I will try to calm my baby by:

____

____

____

I WILL NOT SHAKE MY BABY.

I PROMISE: If I become stressed out, I will place my baby on his/her back in a safe crib and call a friend for help:

Friend:______________________________ Phone:________________

I WILL NOT SHAKE MY BABY.

I PROMISE: I will choose my baby's caregivers wisely. I will tell them not to shake my baby. I will tell them to call me if they are stressed out by crying. I will not leave my baby with anyone who will become angry if my baby cries or bothers them.

I PROMISE TO PROTECT MY BABY BY NOT SHAKING AND TELLING OTHERS NOT TO SHAKE MY BABY.

Parent:______________________________

Date:______________________________