SIBLEY MEMORIAL HOSPITAL
JOHNS HOPKINS MEDICINE

Maternal Fetal Medicine
Building B, 3rd Floor, 5255 Loughboro Road NW
Washington, DC 20016-2695
Phone: 202-660-7180 Fax: 202-660-7189

Rita W. Driggers, MD, FACOG (Medical Director) Julia Timofeev, MD, FACOG Christopher Novak, MD, FACOG

NEW PATIENT REGISTRATION INFORMATION

In order to facilitate your visit, we request that you please read through the following information and answer some questions about your medical history as it pertains to your upcoming visit.

If you need to cancel or change your appointment, please provide a minimum of 24 hour notice.

Medical records and a referral from your medical provider are required prior to making an appointment, in order to ensure that you're scheduled for the appropriate evaluation. Our staff will make every effort to obtain records in a timely manner, so as not to delay your medical treatment.

Please bring with you: a picture ID, insurance card, a referral form from your medical provider (unless already sent electronically by your medical office), and a copy of any other medical records/labs that you consider pertinent to your care that may not be available from your obstetric office (for example, Cardiology evaluation, Rheumatology records, etc).

Please arrive 15 minutes prior to your appointment to allow for completion of the registration process, vital signs, etc.

OFFICE INFORMATION:

We're open Monday – Friday (except for major holidays) from 8am to 4:30pm. Appointment times vary depending on the service provided. For approximate times of most common appointment types please see below:

Ultrasound (longer times will be allotted for twin pregnancies)

- First Trimester Nuchal Translucency Screening – 30-45 minutes, 15-60 minute counseling session
- First trimester dating ultrasound – 30 minutes
- Fetal anatomy ultrasound – 45-60 minutes
- Growth ultrasound – 30 minutes
- Biophysical profile – 30 minutes; 50-60 minutes with non-stress test (NST)

Consultations

- MFM – 30-60 minute initial consultation, 15-30 minute follow up appointments
- Genetic consultation – 30-60 minutes
- Preconception counseling – 45-60 minutes

Other Procedures and Services

- Amniocentesis – 30 minutes, 15-60 minute genetic counseling session
- CVS (chorionic villus sampling) – 30 min, 15-60 minute counseling session
- NST (non-stress test) – 20-30 minutes
- Diabetes management (physician appointments are made for ~1 week post receipt of glucometer):
  *Diabetic log sheets can be obtained online at www.sibley.org/MFM
  ***Please bring a copy of log sheets to all of your appointments**. We will also need information on your current medication regimen and the timing of medication administration
  *For refills on lancets and test strips, please provide your glucometer name (i.e. OneTouch Ultra) and lancing device name (i.e. Delica)

LATE ARRIVAL POLICY:

All patients are asked to arrive 15 minutes before their scheduled appointment time. Your appointment time is when your evaluation is scheduled to start (i.e. an ultrasound). Arriving a few minutes prior allows time for check in and vitals. Due to the nature and duration of the scheduled exams, those arriving 15 minutes or more after their scheduled appointment time will, in most cases, be rescheduled to the next available appointment. We will make all reasonable efforts to provide this appointment the same day, but it may be several hours later or possibly a different day altogether. Strict adherence to this policy allows us to provide quality care and to dedicate the required amount of time to appropriately assess the wellbeing of you and your pregnancy.

Please initial and date here _____ to acknowledge that you have read and understand the Late Arrival Policy.

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GENETIC CONSULTATION INFORMATION

To Our Prospective Patients,
During the course of your care in our office, you may meet with a genetic counselor.

About Genetic Counselors and Genetic Consultation

A genetic counselor is a healthcare professional with a specialized graduate degree, certification, and experience in genetics and counseling. You may be referred by your doctor to meet with a genetic counselor due to your medical, pregnancy, or family history, or due to an increased risk based on age, test results, ultrasound findings, exposures, or other factors. You may also be referred to meet with a genetic counselor by the Maternal Fetal Medicine specialist.

During a genetic consultation and follow up, a genetic counselor will:

- discuss potential genetic risks and available testing options
- provide you with a personalized risk assessment based on your medical, pregnancy, and family history
- explain test results
- provide you with information about a chromosome abnormality, birth defect, or genetic condition of concern
- support you in making decisions about testing options and pregnancy
- coordinate genetic testing, if available and desired
- provide you with referrals to other specialists or resources, as needed

At times, a genetic counseling student may participate in your care. A certified genetic counselor will be present during all student interactions to ensure that you receive clear and appropriate information. You always have the option to decline interaction (observation or counseling) with a genetic counseling student. If a genetic counseling student is present, the same billing policies described below will apply.

About Billing for Genetic Consultation

The cost of a genetic consultation will be billed to your insurance based on the amount of time you spend talking with the genetic counselor (divided into 30 minute increments). When possible, codes are submitted to your insurance company for pre-authorization and approval prior to the consultation. If you would like to contact insurance personally to determine coverage, please use the CPT (procedural) code 96040 for genetic consultation. This is the only CPT code that can be used for genetic consultation and therefore, if your insurance carrier does not cover this CPT code, a different code cannot be used and genetic consultation will not be covered. Please understand that pre-authorization or approval for genetic counseling is NOT a guarantee that the cost of the consultation will be covered by insurance. **There are some insurance companies that do not routinely cover genetic counseling**. Please understand that meeting with a genetic counselor is required prior to having certain genetic tests in our office, including cell-free DNA screening, carrier screening, chorionic villus sampling (CVS), and amniocentesis.

If you receive a bill for genetic consultation, you will be eligible to receive a discount for self-pay. Please contact Patient Financial Services at 202-537-4778 to have the discount applied and to pay your bill.

If you receive a request for medical documentation supporting the need for genetic consultation or testing, please contact our genetic counselor at 202-660-7182.

Thank you!

The Maternal Fetal Medicine Program at Sibley Memorial Hospital

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FIRST TRIMESTER SCREENING AND BILLING

The first trimester screen provides a risk assessment for Down syndrome and two other more severe chromosome abnormalities (trisomy 18 and trisomy 13) in the end of the first trimester of pregnancy (weeks 12-13^{+6}). The first trimester screen combines the results of a specialized ultrasound (nuchal translucency) with a blood test. The ultrasound will be performed in our office at the time of your appointment and your blood will be drawn and sent to NTD laboratories/PerkinElmer for analysis. There are several laboratories that offer first trimester screen blood analysis, HOWEVER, our office will ONLY send a blood sample for first trimester screening to NTD laboratories. We use NTD laboratories because their first trimester combined screen result is the most accurate, detecting up to 95% of cases of Down syndrome, trisomy 18, and trisomy 13 (compared to a detection rate of 85% at some other laboratories). Regardless of which laboratory is in network for your insurance carrier, your first trimester screen blood work will be sent to NTD to provide the risk assessment with the highest accuracy. If your insurance carrier is out of network and you do not have out of network benefits, your first trimester blood sample cannot be sent to a different in network laboratory. You may wish to call your insurance carrier prior to your first trimester screen appointment to determine if your insurance carrier is contracted with NTD laboratories/Eurofins. You may decline first trimester screen blood analysis, however, the most accurate test result is produced from combining the ultrasound results with blood analysis. Please ask the physician and/or genetic counselor if you have further questions at the time of your appointment.

The cost of the first trimester screen blood work through NTD laboratories is $260. If you receive a bill for some, or all, of this amount, you will be eligible for a discounted self-pay rate (typically less than $100). Please contact NTD Laboratories directly at 631-425-0800 to discuss the discounted rate and to pay your bill.

If you receive a request for medical documentation supporting the need for first trimester screening, please contact our genetic counselor at 202-660-7182.

Please read the statement below, and print, sign, and date if you agree.

I have read and understand the first trimester screen and genetic consultation billing policies of the Maternal Fetal Medicine Program at Sibley Memorial Hospital.

Patient's Name Patient's Signature Date

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HELPFUL LINKS

For information regarding your visit at Sibley Memorial Hospital, please visit: https://www.hopkinsmedicine.org/sibley-memorial-hospital/ or https://www.hopkinsmedicine.org/sibley-memorial-hospital/planning-your-visit/

If you have any questions, please contact our office at 202-660-7180 for assistance.

Patient education information can also be accessed on our website, at www.sibley.org/MFM

Thank you!

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PATIENT REGISTRATION INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Date of birth: _____ Social Security Number: _____

Country of Birth:_____Maiden Name: _____ (*for security purposes only)

Address: _____

City: _____ State: _____ ZIP Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Marital Status: _____ Occupation: _____

Employer: _____ Employment Status (circle one): full time / part time / other: _____

Ethnicity (circle one): Hispanic/Latino or Not Hispanic/Latino Race: _____

Partner/Spouse Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN _____

Race: _____ Phone #: _____

Employer/Profession: _____ Employment Status: full time / part time / other: _____

Emergency Contact: (if different from spouse/partner above)

Name: _____ Relation to the Patient: _____ Phone #: _____

Insurance Information: (****please include a front and back copy of your insurance card when sending in this form****)

Insurance Provider _____ Covered through (circle one): current employer / other: _____

Plan (circle one): HMO / PPO / Open Access / Choice Plus / Federal Employee / other: _____

Subscriber/Member ID#: _____ Group #: _____

Address (PO Box #) on back of card for Medical Claims: _____

Is the insurance plan through your spouse/partner's employer (circle one): yes no

Referral Information:

Referring Physician _____ Phone*: _____ Fax*: _____

(*Phone and fax information is not necessary for physicians affiliated with Sibley Memorial Hospital)

Reason for Referral (as stated on the referral form): _____

First Day of Last Menstrual Period: _____

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Age: _____ Due Date:_____

Please tell us your understanding of the reason for referral to high risk obstetrics. _____

_____

_____

List any complications thus far during this pregnancy (i.e. bleeding, cramping, etc.):_____

_____

MEDICAL HISTORY:

Do you have any medical problems?

CONDITION	YES	NO	YEAR DIAGNOSED	COMMENTS
Anemia				
Asthma				
Back problems				
Blood clots				
Blood transfusion				
Cancer				
Anxiety				
Depression				
Diabetes				
Heart problems/murmurs				
Hepatitis or liver disease				
High blood pressure				
Kidney disease/recurrent UTI				
Lupus or other autoimmune disorders (please specify)				
Migraines				
Seizure disorder				
Thyroid problems (please specify hypo or hyperthyroidism)				
Other:				
Other:				

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SURGICAL HISTORY:

Have you had any surgeries or procedures?

DATE OF SURGERY	SURGERY TYPE/ REASON FOR SURGERY	ANESTHESIA (GENERAL OR LOCAL)	ANESTHESIA COMPLICATIONS	COMMENTS

OBSTETRIC HISTORY:

If IVF, date of embryo transfer? _____ Infertility treatment center _____

Please tell us about your pregnancies:

TOTAL # OF PREGNANCIES (INCLUDE CURRENT)	FULL TERM (37+ WEEKS)	PREMATURE (<37 WEEKS)	SPONTANEOUS MISCARRIAGES	TERMINATIONS	MULTIPLE BIRTHS	ECTOPIC PREGNANCY	LIVING CHILDREN

PREGNANCY	DATE	WEEKS AT DELIVERY	BIRTH WEIGHT	MALE OR FEMALE	VAGINAL, CESAREAN, FORCEPS OR VACUUM	TYPE OF ANESTHESIA	COMMENTS/ COMPLICATIONS
1							
2							
3							
4							
5							
6							

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Any children with birth defects *(heart defects, neural tube defects, cleft lip/palate, etc.)*? _____

_____

Any children with developmental delay, autism, or Down syndrome? _____

_____

GYNECOLOGIC HISTORY:

Age at onset of menses: _____ Regular cycles? _____

History of HSV (herpes), gonorrhea, chlamydia, or syphilis? _____

Does your partner have HSV (herpes) or HIV? _____

Date of last PAP smear: _____

History of abnormal PAP smear? _____ if yes, what year? _____ HPV positive? _____

Any treatment of the cervix *(biopsy, excisional cone/LEEP, cryotherapy)?* _____

SOCIAL HISTORY:

Do you smoke or have you ever smoked cigarettes? _____

If yes, how much and for how long? _____

Do you drink alcohol? _____ if yes, how much?_____ during pregnancy? _____

Do you or have you used recreational drugs? _____

If yes, what drugs, how much, and when?_____

Have you had exposures to chemicals, pesticides, X-rays, or cat litter box during this pregnancy?_____

If yes, please list type of exposure, duration, and date(s) of exposure:_____

_____

Have you had exposure to infections during this pregnancy *(i.e. fever, rash, etc.)*?_____

If yes, please list type of exposure, duration, and date(s) of exposure:_____

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FAMILY HISTORY: *(please mark any that apply with an "X", be as specific as possible – ex: maternal grandfather)*

	YOUR MOTHER	YOUR FATHER	YOUR BROTHER OR SISTER (circle one)	OTHER CHILD (write in gender)	OTHER RELATIVE	FATHER OF BABY	COMMENTS
Birth defects							
Blood clotting disorder							
Blindness							
Congenital heart defect							
Cystic fibrosis							
Chromosomal disorder							
Cleft lip or palate							
Diabetes							
Deafness							
Dwarfism							
Early onset cancer							
Galactosemia							
Huntington disease							
Heart problems							
Hemophilia							
High blood pressure							
Hydrocephalus							
Intellectual disability, autism, Down syndrome, Fragile X syndrome							
Infant or childhood death							
Kidney problems							
Multiple (3 or more) miscarriages							
Muscular dystrophy							
Neural tube defect							
Phenylketonuria							
Other metabolic disease							
Sickle cell disease							
Thalassemia							
Tay Sachs disease or carrier							
Thyroid problems							
Any other:							

Have you or your partner had genetic screening? *(if yes, please explain)* _____

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ALLERGIES:

Are you allergic to any medications? _____ *(if yes, please list medication name and reaction below)*

MEDICATION	ALLERGIC REACTION *(ex. rash, difficulty breathing, swelling)*

Do you have LATEX allergies? *(if yes, include reaction)*_____

Are you allergic to IODINE? *(if yes, include reaction)* _____

HOME MEDICATIONS: *(please also include over the counter and any herbal medications)*

MEDICATION	DOSE/FREQUENCY	CHECK IF TAKEN DURING PREGNANCY

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REVIEW OF SYSTEMS (symptoms you are currently experiencing)

General
□ Weight loss
□ Fever or chills

Skin
□ Rashes
□ Itching

Head
□ Headache

Eyes
□ Vision Loss/Changes
□ Blurry or double vision
□ Flashing lights

Nose
□ Stuffiness
□ Itching
□ Nosebleeds

Throat
□ Bleeding
□ Sore throat
□ Non-healing sores

Neck
□ Swollen glands
□ Pain

Breasts
□ Lumps
□ Discharge

Respiratory
□ Cough
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath at rest
□ Swelling

Gastrointestinal
□ Heartburn
□ Nausea/vomiting
□ Rectal bleeding
□ Constipation
□ Diarrhea

Urinary
□ Burning or pain
□ Blood in urine

Vascular
□ Calf pain with walking
□ Asymmetric swelling

Musculoskeletal
□ Muscle or joint pain
□ Back pain
□ Redness of joints

Neurologic
□ Fainting
□ Seizures
□ Numbness
□ Tingling

Hematologic
□ Ease of bruising
□ Ease of bleeding

Endocrine
□ Sweating
□ Thirst

Psychiatric
□ Nervousness/anxiety
□ Stress
□ Depression

□ Other _____