Congratulations! Attached is the Obstetric Intake to register for prenatal care. Please fill these forms out completely as it will allow us to provide you with the most appropriate care during your pregnancy. If you answer *"Yes"* to any of the questions, please provide a brief explanation on the bottom of the second page. Complete all boxes, including *Total Pregnancies, Number of deliveries, Miscarriages, Ectopic pregnancies, Elective abortions and Living Children.*

*****DO NOT INCLUDE ANY SOCIAL SECURITY NUMBERS ANYWHERE IN THIS PACKET**** **PLEASE INCLUDE ALL DETAILS OF YOUR MEDICAL AND OBSTETRIC HISTORY SO WE CAN ENSURE YOU GET BOOKED WITH THE RIGHT PROVIDER TYPE**

When we receive your paperwork, a nurse will call you to schedule your first OB visit. This appointment will take place between 10-13 weeks of pregnancy based on the date of your last cycle, and will be with a nurse practitioner, midwife, or physician depending on your health history. All prenatal lab work will be ordered at this appointment.

If you are transferring from another OB clinic, please ensure you complete the **Authorization for Disclosure of Medical or Dental Information** form so that we may request your OB records. If you have had previous C-section deliveries, please complete a separate authorization for each one so that we can request an operative report from the facility you delivered at.

Return the completed packet by delivering it to the Women's Health Department front desk (NMCP, Building 2, 4th Floor), faxing it to 757-953-4947, or emailing it to:
usn.hampton-roads.nmrtc-portsmouth-va.list.nmcp-womenshlthclinic@health.mil

If you have not heard from us within 3 business days from the day of submission, please call 757-953-4300 to ensure we received your intake paperwork.

Thank you very much, and we look forward to serving you!

HEIGHT:
PRE-PREGNANCYWEIGHT:
BMI:

OBSTETRICAL PATIENT INTAKE

Date:	Full Name:	DOD ID #:	DOB:
Street Address:		City:	
State:	Zip:	Cell#: Home #: Email:	Work #:
Emergency Contact Name:		Emergency Contact #:	Marital Status:

First Day of your Last Menstrual Period:	**Allergies and Reaction:**	**Current Medications:**

Total Pregnancies:	# Deliveries 37 Weeks or Greater	# Deliveries Less than 37 Weeks	# Miscarriages	# Elective Abortions	# Ectopics	# Living Children

PRE-PREGNANCY WEIGHT_____ **HEIGHT**_____

****PLEASE LIST DETAILS TO "YES" ANSWERS ON THE BACK OF THIS PAGE AND LIST THE # ASSOCIATED WITH THAT ANSWER****

1. History of Diabetes / Gestational Diabetes?	( ) Yes ( ) No	26. Date of last Pap Smear?	
2. Hypertension? (High Blood Pressure)	( ) Yes ( ) No	27. History of Abnormal PAP? If so, what year?	( ) Yes ( ) No
3. Pre-eclampsia?	( ) Yes ( ) No	28. History of Sexually Transmitted Infection?	( ) Yes ( ) No
4. Autoimmune Disorder?	( ) Yes ( ) No	29. Do you or your partner have Genital Herpes?	( ) Yes ( ) No
5. Kidney Disease?	( ) Yes ( ) No	30. Uterine Anomalies?	( ) Yes ( ) No
6. Frequent Urinary Tract Infection?	( ) Yes ( ) No	31. Treatment for Infertility?	( ) Yes ( ) No
7. Neurologic Disorder / Epilepsy?	( ) Yes ( ) No	32. GYN Surgery?	( ) Yes ( ) No
8. Psychiatric History / Depression?	( ) Yes ( ) No	33. Recurrent pregnancy loss (>3) or stillbirth?	( ) Yes ( ) No
9. Hepatitis / Liver Disease?	( ) Yes ( ) No	34. Significant Family History (Cancer, Diabetes, etc)	( ) Yes ( ) No
10. Anemia that Required Medication?	( ) Yes ( ) No	35. Have you had the Chicken Pox? AGE?	( ) Yes ( ) No
11. Phlebitis / Varicose Veins?	( ) Yes ( ) No	36. Varicella Vaccine? AGE?	( ) Yes ( ) No
12. Thyroid Dysfunction?	( ) Yes ( ) No	37. Flu Vaccine? WHEN?	( ) Yes ( ) No
13. Pulmonary History (TB, Asthma, etc.)?	( ) Yes ( ) No	38. PPD? WHEN?	( ) Yes ( ) No
14. History of a Blood Transfusion?	( ) Yes ( ) No	39. Live with someone with TB or exposed to TB?	( ) Yes ( ) No
15. Negative Blood Type? (Rh)	( ) Yes ( ) No	40. High risk for Hepatitis?	( ) Yes ( ) No
16. Tobacco use prior to pregnancy?	( ) Yes ( ) No	41. Up To Date on Vaccinations?	( ) Yes ( ) No
17. Tobacco use since Last Menstrual Period?	( ) Yes ( ) No	42. History of Gastric Bypass Surgery?	( ) Yes ( ) No
18. Alcohol use prior to pregnancy?	( ) Yes ( ) No	43. Concerned about weight gain in pregnancy?	( ) Yes ( ) No
19. Alcohol use since Last Menstrual Period?	( ) Yes ( ) No	44. Nutrition Consult Requested?	( ) Yes ( ) No
20. Street Drug use prior to pregnancy?	( ) Yes ( ) No	45. Surgery/Hospitalizations other than childbirth?	( ) Yes ( ) No
21. Street Drug use since Last Menstrual Period?	( ) Yes ( ) No	46. Complications with Anesthesia?	( ) Yes ( ) No
22. Breast Concerns?	( ) Yes ( ) No	47. Any other chronic medical conditions?	( ) Yes ( ) No

OBSTETRICS PATIENT INTAKE FORM CONTINUED

1A. Will you be 35 or greater at time of delivery? ( ) Yes ( ) No			
For Questions 2- 15, have you or a family member been diagnosed with:			
2A. Thalassemia?	( ) Yes ( ) No	9A. Down Syndrome?	( ) Yes ( ) No
3A. Tay-Sachs Disease?	( ) Yes ( ) No	10A. Hemophilia? (Bleeding Disorder)	( ) Yes ( ) No
4A. Sickle Cell Disease or Trait? (Circle Which)	( ) Yes ( ) No	12A. Cystic Fibrosis?	( ) Yes ( ) No
5A. Neural Tube Defects? (Spina Bifida, Anencephaly)	( ) Yes ( ) No	13A. Huntington Chorea?	( ) Yes ( ) No
6A. Congenital Heart Defect?	( ) Yes ( ) No	14A. Mental Retardation	( ) Yes ( ) No
7A Muscular Dystrophy?	( ) Yes ( ) No	15A. Autism?	( ) Yes ( ) No
8A. Inherited Genetic or Chromosomal Disorders?	( ) Yes ( ) No	16A. Do you or the Father of the Baby have a child with birth defects?	( ) Yes ( ) No
****Circle ALL That Apply**** **Are you of African, Mediterranean, Haitian, Greek, Asian, Jewish, Cajun, or French Canadian descent? ( )Yes ( )No			

****IF YOU DESIRE CYSTIC FIBROSIS SCREENING, PLEASE ANSWER THE FOLLOWING QUESTIONS****

1B. What is the ethnicity of your mother?	3B. Is there a history of CF in your family?	( ) Yes ( ) No
2B. What is the ethnicity of your father?	4B. Do you have CF? If yes, do you have symptoms?	( ) Yes ( ) No

1C. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	( ) Yes ( ) No
2C. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	( ) Yes ( ) No
3C. Within the last year, has anyone forced or threatened you to have sexual activities with them?	( ) Yes ( ) No

****PAST PREGNANCIES/DELIVERIES:**

Date: Month/Year	Weeks	Length of Labor	Birth Weight	Male or Female	C-Section or Vaginal Delivery	Anesthesia	Place of Delivery	Preterm Yes/No	Complications: Bleeding, Vacuum/Forceps Delivery, Shoulder Dystocia, etc.

****USE THE REST OF THIS PAGE TO EXPLAIN ANY "YES" ANSWERS.**

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
Women's Health Departmental SOP	16 Mar 2011

LOCAL FORM TITLE *(Optional)*
OB/GYN Clinic No Show Policy Statement

NO SHOW POLICY
OB/GYN CLINIC
Naval Medical Center Portsmouth

We are committed to offering you and your family the best medical care available and delivering this care in a timely fashion. In an effort to accomplish this mission, we need your help. So, we ask that you carefully read the following policy and understand that we are committed to meeting your healthcare needs.

1. **Active Duty:**
   a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
   b. I understand if I miss a scheduled appointment that my chain of command may be notified and this may result in being charged with an unauthorized absence.
   c. I understand if I am not able to keep my appointment, I will be held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.

2. **Family Members:**
   a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
   b. I understand that if I am not able to keep my appointment, I am held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.
   c. Failure to call the OB clinic prior to my appointment will result in a "NO SHOW".

Clinic "NO SHOWS" result in setbacks to your treatment plan and prevents other patients from being scheduled in your place.

Patient's Signature: _____ Date: _____

Sponsor's Signature: _____ Date: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

HOSPITAL OR MEDICAL FACILITY	STATUS
DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN
RELATIONSHIP TO SPONSOR	

Category _____

MEDICAL RECORD - SUPPLEMENTAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE

GENETIC CARRIER SCREENING

Genetic carrier screening is a test that looks at your genes to determine whether you are a carrier of certain genetic disorders. A positive result tells you with greater than 99% certainty that you are a carrier of a specific genetic disorder, and you could be at risk of having an affected child. If a risk is identified, you may wish to consider genetic carrier screening for your partner, consult with your health-care provider, or pursue genetic counseling. If you are pregnant, prenatal testing can be performed to find out whether your baby has inherited the genetic disorder. We currently offer carrier screening for the following disorders:

Cystic fibrosis (CF) is a genetic disorder and leads to life-long illness. It causes the body to produce very thick mucus that can damage internal organs. It can lead to chronic lung infections, digestive problems, poor growth and infertility. Symptoms range from mild to severe, but do not affect intelligence. On average, CF patients live into their mid to late thirties. About 1 in every 3,500 babies born in the U.S. has cystic fibrosis. Screening of newborns for cystic fibrosis is now performed in every state.

Spinal muscular atrophy (SMA) is a genetic disorder that affects the control of muscle movement. It affects a person's ability to control their muscles, including those involved in breathing, eating, crawling and walking. SMA has different levels of severity, none of which affect intelligence. However, the most common form of the disorder causes death by age two. About 1 in every 6,000 to 1 in every 10,000 babies born in the US has SMA.

No test can detect 100% of genetic carriers. Even if your test results are negative, it is still possible that you could be a carrier of the genetic disorder, but the chance is small.

For the most accurate interpretation of test results, the laboratory needs correct information about your ethnic background, family history of genetic disorders and family relationships (especially paternity).

The decision to accept or decline genetic carrier screening is completely yours.

Your test results are confidential and will become a part of your medical record. Your test results will be sent only to the health-care provider who ordered the test, or his/her agent, unless otherwise authorized by you or required by law. Your health-care provider is responsible for interpreting the test results and explaining them to you. No other test will be performed and reported on your sample unless authorized by your health-care provider.

Before signing this form, I have had the opportunity to discuss genetic carrier screening with my health-care provider or someone he/she has designated. I understand that genetic counseling will be recommended if both I and my partner are carriers. My questions have been answered and I have all the information I need to make a decision at this time.

☐ **I want** carrier screening for CF

☐ **I do not want** carrier screening for CF

☐ **I want** carrier screening for SMA

☐ **I do not want** carrier screening for SMA

Patient Name (please print)

Patient Signature

Witness Signature

Date

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION:*(For typed or written entries, give: Name - Last, first, middle: SSN: Sex: Date of Birth: Rank/Grade.)*

HOSPITAL OR MEDICAL FACILITY	STATUS
DEPARTMENT / SERVICE	RECORDS MAINTAINED AT:
SPONSOR'S NAME	SSN
RELATIONSHIP TO SPONSOR	

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
ATTN TEAM NURSE FOR: Green Team____ Gold Team ____ Violet Team____ Blue Team____	620 JOHN PAUL JONES CIRCLE, BLDG 2 4TH FLOOR 4C&D PORTSMOUTH, VA 23708
c. TELEPHONE *(Include Area Code)* (757) 953-4300	d. FAX *(Include Area Code)* (757) 953-4947

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	☐ DATE *(YYYYMMDD)* ☒ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Genetic Counseling is available at Naval Medical Center Portsmouth. Please answer the questions below to see if this service may be helpful to you. Your medical care provider will review this form and give you guidance. Not every Yes answer will need referral.

Your Name: **DOD Number:**	**Date:**
Your Partner's Full Name:	
Are You Adopted?*	Yes No
Is Your Partner Adopted?*	Yes No
Are you and your partner genetically related to each other?* (i.e. [1] cousins)	Yes No
Have you and/or your partner had genetic testing? If yes, was it a large carrier panel? *(please provide a copy of the results to OB provider)* If yes, what were you tested for? *(please provide a copy of the results to OB provider)*	Yes No Yes No
Are you pregnant?	Yes No
If pregnant, was donor egg, donor sperm or donor embryo used?	Yes No
Have you and/or your partner had 3 or more pregnancy losses? *(^If yes, OB provider will order karyotype(s), APs, and other labs as clinically indicated)*	Yes No
*(*Genetic Consult)*	
Ancestry *(check all that apply)*	**You Partner** (check all that apply)
African or African American~	[ ] [ ]
Ashkenazi Jewish*	[ ] [ ]
Asian/Pacific Islander'	[ ] [ ]
Cajun or French Canadian*	[ ] [ ]
European Caucasian (English, Irish, German, etc.)	[ ] [ ]
Hispanic (Mexico, Puerto Rico, Central or South America)~	[ ] [ ]
Indian (India)	[ ] [ ]
Mediterranean (Greece, Italy, Turkey, etc.)'	[ ] [ ]
Middle Eastern (Egypt, Iran, Iraq, Lebanon, etc.)	[ ] [ ]
Native American	[ ] [ ]
Southeast Asia (China, Laos, Vietnam, etc.)'	[ ] [ ]
Other (write here)	[ ] [ ]
*(~hgb electrophoresis, 'CBC, *Genetic Consult)*	
Medications/Supplements/Harmful Substances while pregnant	
Prescription medications - list them:	Yes No
Over the counter medications - list them:	Yes No
Vitamins/supplements - list them:	Yes No
Smoking/Vaping (circle which) If yes, how much? Quit? Yes No Quit When?	Yes No
Alcohol (beer, wine, liquor) If yes, how much? Quit? Yes No Quit When?	Yes No
Street Drugs (marijuana, cocaine, heroin, ecstasy, etc.) If yes, what drug(s)? Quit? Yes No Quit When?	Yes No
(OB provider to determine if exposures are significant and need referral)	

Personal and Family Health Conditions *(you, your family, partner, partner's family)* *[Be very specific, such as: my father's sister's son or partner's mother's brother]*	
Blindness under age 20yo (who?)	Yes No
Deafness under age 20yo (who?)	Yes No
Spina Bifida (who?)	Yes No
Anencephaly (who?)	Yes No
Hydrocephalus (water in brain) (who?)	Yes No
Muscular dystrophy (who?)	Yes No
Blood disorders (what? who?)	Yes No
Hemophilia (who?)	Yes No
Sickle cell disease/trait (who?)	Yes No
Thalassemia (who?)	Yes No
Cystic fibrosis (thick mucus in lungs) (who?)	Yes No
Spinal muscular atrophy (SMA) (who?)	Yes No
Tay Sachs disease (who?)	Yes No
Bone deformities (what? who?)	Yes No
Dwarfism (who?)	Yes No
Club Foot/Feet (who?)	Yes No
Extra/missing fingers/toes/bones/limbs (who?)	Yes No
Brittle bones under age 20yo (who?)	Yes No
Intellectual disability (what? who?)	Yes No
Autism (who?)	Yes No
Fragile X syndrome (who?)	Yes No
Cleft lip/cleft palate (who?)	Yes No
Marfan syndrome (who?)	Yes No
Ehlers Danlos - *Vascular type* (who?)	Yes No
Heart defect at birth needing surgery (who?)	Yes No
Cerebral Palsy (who?)	Yes No
Abnormal kidneys (what? who?)	Yes No
Cystic kidneys (who?)	Yes No
Extra or missing kidneys (who?)	Yes No
Dialysis at young age (who?)	Yes No
Chromosome syndrome (what? who?)	Yes No
Down syndrome (who?)	Yes No
Deletion or duplication syndrome (who?)	Yes No
Translocation (who?)	Yes No
Seizures (who?)	Yes No
Miscarriages (3 or more each) (who?)	Yes No
Stillbirth (who?)	Yes No
Infant death (who?)	Yes No
Other Genetic conditions (what? who?)	Yes No
Other birth defects (what? who?)	Yes No
(For page 2 - OB provider to determine if Genetic Counseling referral is indicated)	