EMORY CLINIC

Department of Human Genetics

Dear Parent / Guardian of: _____

Your child's appointment in the General Pediatrics Genetics Clinic is scheduled for:
_____at _____am pm.
Please arrive at the clinic by _____am pm.

Genetic counseling and evaluation by a physician are each services provided for a fee. Emory Clinic Department of Human Genetics will bill your insurance company within one week of your appointment. Please bring your child's insurance card to the appointment. You are responsible for any charges not covered by insurance as well as preauthorization for services that may be required by your insurance company.

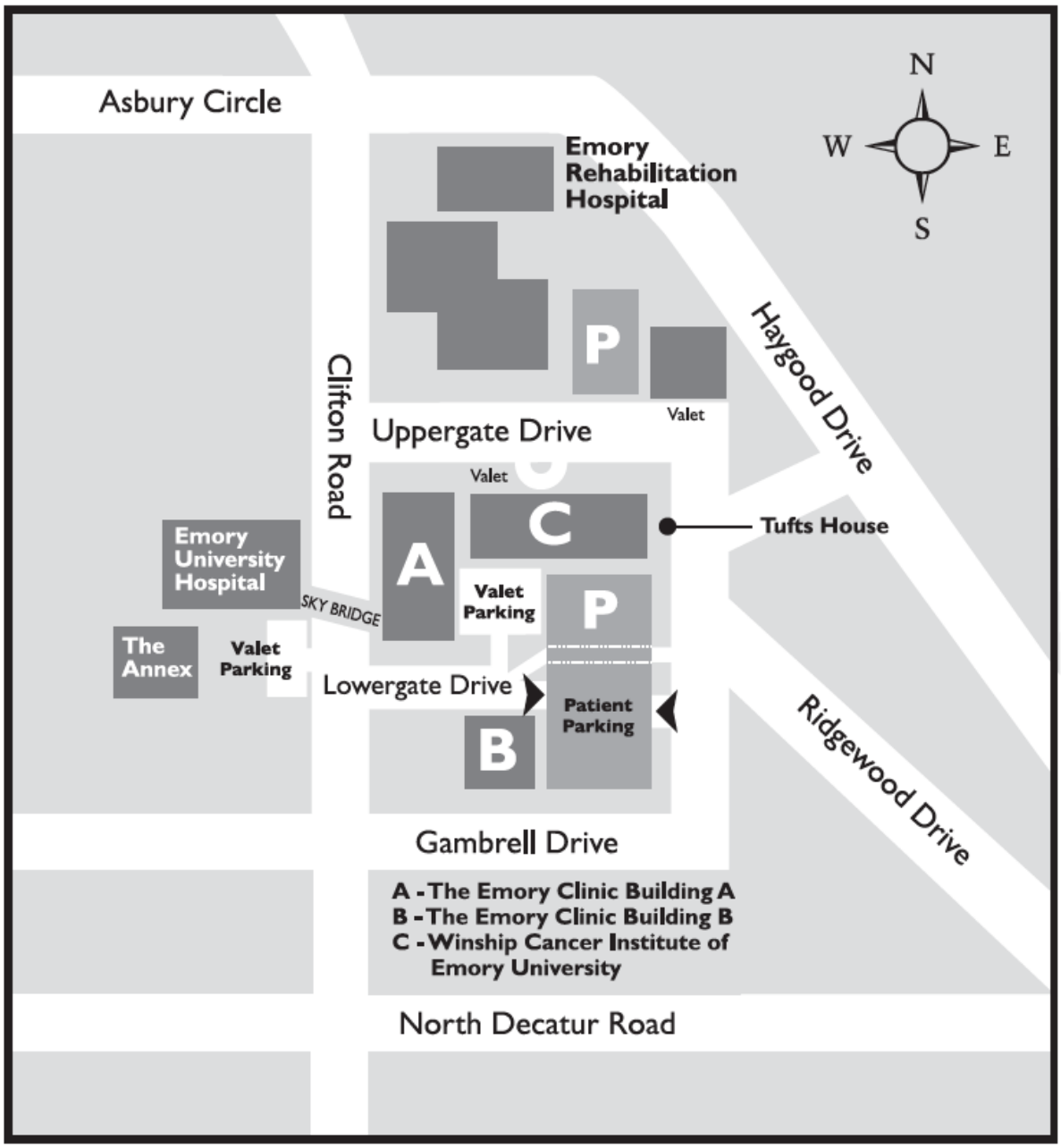
FOR ALL APPOINTMENTS:

- The attached Questionnaire is for you to complete regarding your child. Please return it to us BEFORE YOUR APPOINTMENT via email to the address below (Attn: Pediatric Clinic) or via fax (404-778-8562). **It is important that we receive this information prior to the appointment, as it helps us establish an appropriate evaluation plan for your child.**
- Please allow for an extra 15-20 minutes before your appointment for parking. Fees for parking range from $4 to $8 depending on your length of stay. Valet parking is a flat rate of $8.
- Please arrive **30 minutes** before your scheduled appointment time for registration, insurance processing, and patient triage.
- **If you arrive 20 minutes or more after your scheduled appointment time, your appointment is subject to cancellation.** Decisions regarding these matters are left to the discretion of the clinicians.
- Please plan to spend approximately **2 hours** at Emory Genetics.
- Be sure to bring your child to this initial appointment and all follow-up appointments in the Pediatric Genetics Clinic. If you feel that your child might distract you from listening to what the counselor/physician has to say, try to bring another adult with you to supervise the child in the waiting area. **An appointment in this clinic cannot take place without the child present.**
- If you cannot keep your appointment, please call 404-778-8570 as far in advance as possible so that we can offer this appointment to another patient.

The enclosed packet should contain the following forms:

- This cover letter
- Directions to Emory Genetics Clinic
- Emory Clinic Department of Human Genetics Patient Registration Form
- Financial Services Statement
- Special Questionnaire Regarding your Child's Genetics Clinic Visit

Thank you,
Emory Genetics


Asbury Circle
N
W
E
S
Emory Rehabilitation Hospital
P
Valet
Haygood Drive
Clifton Road
Uppergate Drive
Valet
C
Tufts House
A
Emory University Hospital
SKY BRIDGE
Valet Parking
P
The Annex
Valet Parking
Lowergate Drive
Patient Parking
B
Ridgewood Drive
Gambrell Drive
A - The Emory Clinic Building A
B - The Emory Clinic Building B
C - Winship Cancer Institute of Emory University
North Decatur Road

EMORY CLINIC

Department of Human Genetics

PATIENT REGISTRATION FORM

PATIENT (CHILD) INFORMATION			
Name:			
Address:			
City, State, Zip:			
Home Telephone: ( )			
Date of Birth: Sex: M F Child's Social Security #:			
PARENTAL / BILLING INFORMATION			
	MOTHER'S INFORMATION	FATHER'S INFORMATION	LEGAL GUARDIAN'S INFORMATION
Name:			
Address:			
City, State, Zip:			
Home Telephone:	( )	( )	( )
Social Security #:			
Date of Birth:			
Employer:			
Employer's Address:			
City, State, Zip:			
Work Telephone:	( )	( )	( )
With whom does the patient reside? (**Circle one**) Mother Father Legal Guardian			
Language (if not English): Other – please specify:			

Referred By:
Physician _____ Specialty _____
Address _____ City_____ State _____ Zip _____
Telephone (__)_____ Pre-cert #_____

Primary Care Physician:
Name: _____ Phone: _____
Address: _____
Chief Complaint (Reason for Visit): _____
Please provide insurance information below:

MEDICAID
Insured's Name:
_____ Medicaid # (include letters):

Please check one:
- GBHC # _____
- HMO _____
- Family Plus _____
- American _____
- Other _____

INSURANCE POLICY NO. 1
Insured's Name:
_____
ID # (include letters):
_____
Group # or Name:_____
Ins. Co. Name:
_____
Address for Mailing Claims:_____
_____

INSURANCE POLICY NO. 2
Insured's Name:
_____
ID # (include letters):
_____
Group # or Name:_____
Ins. Co. Name:
_____
Address for Mailing Claims:_____
_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the Emory Clinic Department of Human Genetics. I understand I am financially responsible for non-covered services, remaining deductible and co-pay. I also authorize the Emory Clinic Department of Human Genetics to release any information required in the processing of this claim.

_____

Signed (Patient or Parent of Minor) Date

In case of emergency, please notify:

Name_____ Telephone No._____

Address_____

Patient's Name: _____
Date of Birth: _____
Name of person filling out form / relationship to patient: _____

A Special Questionnaire Regarding Your Child's Genetics Clinic Visit

In order to help us develop an appropriate evaluation plan for your child BEFORE you arrive for your appointment, it is essential that you complete this questionnaire to the best of your ability.

Part of a genetics evaluation involves looking at a person's physical features. These physical features may suggest certain genetic conditions and rule out others. We ask that you provide a CLEAR, RECENT photograph of your child so that we may begin to evaluate for these things ahead of time. Feel free to include any pictures that are relevant to the reason your child has been referred. We will be able to return these photos to you if you need them at your clinic visit.

If English is not your first language and you are having trouble filling out this form, please contact us at 404-778-8570 and we will be happy to assist you.

Attach Photograph Here

What are the main reasons why your child's doctor has requested this genetic evaluation? What questions / concerns do you have about your child? _____
_____
_____
_____
_____

Is your child adopted? Yes _____ No _____
Is the child being seen today currently in foster care? Yes _____ No _____

*If **YES**, to either question above, please fill out this questionnaire to the best of your ability.*

Pregnancy History (For the pregnancy of the child with the appointment)

Mother's age at delivery? _____ Father's age at delivery? _____

The pregnancy was confirmed by (**circle one**) blood test / urine test at about _____ (**circle one**) weeks / months.

What number pregnancy was this for the mother (1st, 2nd, 3rd, etc.)? _____

When did the mother begin prenatal care? (**circle one**)
1st Trimester *2nd Trimester* *3rd Trimester* *No prenatal care*

Please answer the following Yes / No questions about the pregnancy, providing detail where appropriate. Use the back of the page if necessary.

Question	Yes	No	Detail
Prenatal vitamins?			
Medications (prescription)?			
Medications (over-the-counter)?			
Smoking?			
Alcohol (beer, liquor, wine)?			
Street drugs?			
Illness / Infection?			
Bleeding?			
Rash?			
Fever?			
Diabetes?			
High blood pressure?			
Thyroid Problems?			
X-rays / radiation?			
Premature labor?			
Hospitalization? (Do not count the delivery/birth)			
Abnormal growth of baby?			
Other concerns?			

Please answers the following Yes / No questions regarding testing that may have been done during the pregnancy.

Category	Test	Yes	No	Don't Know
Screening	First Trimester Screen (ultrasound of baby's neck / Nucal Translucency / NT measurement plus blood work)			
	Second Trimester Screen (Triple Screen, Quad Screen, AFP Test)			
Diagnostic Testing	Chronic Villus Sampling (CVS)			
	Amniocentesis			
Other	Glucose Tolerance Test			
	Routine Ultrasound			
	Specialized Ultrasound			
	Other (please explain)			

Were any of the tests ABNORMAL? If **YES**, please explain: _____
_____
_____
_____
_____

First movements of the baby were felt at: _____ weeks / months (**circle one**): *Yes* *No*

Were the baby's movements normal during the pregnancy? (**circle one**): *Yes* *No*

Mother's total weight gain during pregnancy: _____pounds

Birth History (For birth of the child with the appointment)

Due date: _____ Date delivered: _____

The child was born (**circle one**): *Early* *On Time* *Late*

If early or late, by how many weeks? _____

Birth Hospital (if not in GA, please include the state): _____

Was the labor (**circle one**): *Spontaneous (happened on its own)* *OR* *Induced?*

If **induced,** please explain the reason why and the method used (ex: doctor broke your water, pitocin, etc.) if known: _____
_____
_____

How was the child delivered? (**circle one**): *Vaginal* *C-section*

If **C-section**, please explain the reason why (ex: previous child born that way, failure to progress, etc.): _____
_____
_____

Was the baby born head first? (**circle one**): *Yes* *No* *I don't know*

Baby's weight: _____ Baby's length:_____ Baby's head size:_____

Were there complications with the delivery? (**circle one**): *Yes* *No*

If **YES**, please list complications:_____

Were there any problems right after birth (ex: need to go to the NICU, breathing problems, jaundice, etc)? (**circle one**): *Yes* *No*

Did the baby have any feeding difficulties? (**circle one**): *Yes* *No*

If **YES** to either question, please explain:_____
_____
_____
_____
_____

Was your child born with any birth defects (ex: club foot, cleft lip and/or cleft palate, heart defects, extra fingers, etc.)? (**circle one**): *Yes* *No*

If **YES**, please explain:_____
_____

After the baby was born, how did he/she feed? (**circle one**): *Breast* *Bottle* *Other*

If **Other**, please explain: _____
_____

Your baby was discharged home at_____ days / weeks (**circle one**)

Past Medical History

Please answer the following Yes / No questions about possible tests / procedures / etc. that your child may have had. If your child has had one of these things, please provide more detail in the far right box. Use the back of the page for extra space if you need it.

Category	Has your child…	Yes	No	Comment (When? Why? Where? Results?)
General	Had a formal eye examination with pediatric ophthalmology?			
	Had a formal hearing examination?			
	Been hospitalized overnight?			
	Had surgery?			
	Currently taking any medications?			
	Been tested for allergies?			
Genetics	Ever had genetic testing?			
Imaging	Had an MRI of the **brain**?			
	Of the kidney?			
	Of the heart?			
	Had a CT scan of the brain?			
	Of the kidney?			
	Of the heart?			
	Had an ultrasound of the **brain**?			
	Of the kidney?			
	Of the Heart (echocardiogram)?			
	Had an X-ray of the **brain**?			
	Of kidney?			
	Of heart?			
	Had any other special procedures (ex: EEG, swallow study, etc.)?			

Does your child have any significant problems with any of the following?

	Yes	No	Describe
Unusual weight gain or loss			
Eyes / vision			
Hearing			
Ears / Nose / Mouth / Throat			
Teeth			
Lungs / Breathing			
Heart / Veins / Arteries / Circulations			
Stomach/ Intestines/ Bowels			
Kidney/ Bladder/ Genitals			
Bones/Muscles (pain, weakness, abnormalities, etc.)			
Joint pains / Swelling / Stiffness			
Skin / Hair / Nails			
Easy bruising / Bleeding or poor wound healing			
Headaches / Seizures			
Loss of balance or coordination			
Loss of developmental skills			
Sleep disturbances / Problems			
Behavior / Psychological Problems			
Growth			
Heat or cold intolerance			
Delays or problems with puberty			
Hormones			
Other (please describe)			

Early Development

WHEN did you or your doctor first become concerned about your child's development?

_____

_____

If there are any concerns about your child's development, **HOW** were they noticed?

_____

_____

*Other than a pediatrician, what doctors is your child **ACTIVELY** seeing?* (*Please list specialty and name, if known).*

Name of Doctor	Specialty (ex: neurology, cardiology, GI, etc.)	Reason your child is seen	How often child sees this doctor (ex: once a year, every 3 months, etc.)

*Other than a pediatrician, what doctors has your child seen **IN THE PAST?***

Name of Doctor	Specialty (ex: neurology, cardiology, GI, etc.)	Reason your child was seen	Date of last visit with this specialist

How old was your child when he/she began:

Rolling Over? _____
Crawling? _____
Cruising? _____
First word?_____
Toilet trained? _____

Sitting alone?_____
Pulling to stand? _____
Walking alone? _____
Sentences? _____

Has your child lost any skills that he/she previously mastered (regression)? (**circle one**): *Yes No*
If **YES**, please explain:_____
_____

School Information

Does your child currently attend school or daycare? (**circle one**): *Yes No*
If **YES**, what is the name of the school / daycare? _____
Grade (if applicable)? _____

Does your child attend special classes or need special help? (**circle one**): *Yes* *No*
If **YES,** please explain. (For example, what subjects does he/she need help in? Is he/she in an inclusion class or self-contained class? **If possible, please send us a copy of your most recent IEP).** _____
_____
_____
_____

Does your child receive any of the following?	**Yes**	**No**	**How often?**
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Other Therapy (please describe)			

Does your child have any behavioral problems? (**circle one**): *Yes* *No*
If **YES**, please explain: _____
_____
_____

Do you feel that your child's language skills are where they should be for your child's age? (**circle one**): *Yes* *No*
If **NO**, please explain: _____
_____
_____

Has your child even had IQ testing or a formal developmental assessment? (**circle one**): *Yes* *No*
If Yes, **when?** And **what** were the results? **Please send us a copy if possible.**
_____
_____
_____

Family History

Are Biological parents related to one another (blood relatives)? *Yes* *No* *Don't Know*

Are the patient's biological parents still together? *Yes* *No* *Don't Know*

Are the biological parents thinking of having more children? *Yes* *No* *Don't Know*

Is the biological mother (or partner the biological father, if applicable) currently pregnant?
Yes *No* *Don't Know*

Has the patient been known by any other names in the past?
Yes *No* *Don't Know*

Patient Name: _____ *Date of birth:* _____

Please complete all sections and return to Medical Genetics two weeks prior to your visit. If you need additional space, use the backs of the pages and indicate which section (A, B, C, D) is being supplemented.

SECTION A: PATIENT INFORMATION

Patient name: _____ Birthdate: ___/___/___ Sex: M___F___.

Has the patient ever been known by any other name(s)? If **yes,** what name(s):_____.

SECTION B: PATIENT'S SISTERS AND BROTHERS

Please list--include miscarriages of the patient's mother. Indicate "**S**" for sisters/brothers with the **Same** two parents, "**M**" for sisters/brothers who have only the same **Mother** as the patient, or "**F**" for sisters/brothers who have only the same **Father** as the patient. Use back of page if needed.

Name	S/M/F	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)
					Yes No	
					Yes No	
					Yes No	
					Yes No	

Patient Name: _____ *Date of birth:* _____

SECTION C: PATIENT'S PARENTS AND THEIR SISTERS AND BROTHERS, i.e. THE AUNTS AND UNCLES OF THE PATIENT

Indicate "**S**" for sisters/brothers with the **Same** two parents, "**M**" for sisters/brothers who have only the same **Mother**, or "**F**" for sisters/brothers who have only the same father.

Name	S/M/F	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)
Patient's mother			F		Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

Patient's father			M		Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

SECTION D: PATIENT'S GRANDPARENTS

Name	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death
Mother's father		M		Yes No	
Mother's mother		F		Yes No	
Father's father		M		Yes No	
Father's mother		F		Yes No	