



**CEDARS-SINAI MEDICAL CENTER**  
**Medical Genetics**

Dear Parent(s),

Thank you for expressing interest in our Genetics Clinic. Enclosed, you will find the following paperwork necessary for your child's appointment:

- A Genetics questionnaire
- Registration Form
- Authorization for Use or Disclosure of Health Information (see below)

It may seem like a lot of paperwork, but it is necessary and helpful to our staff in preparing for your child's visit. Please make sure to take the time to fill out the questionnaire completely and remember to return the packet to us as soon as you can. Unfortunately, we do need to receive the packet before we are able to schedule an appointment. The completed questionnaire and any medical records that are sent will be reviewed by one of our genetic counselors to ensure that our Genetics team has the appropriate information so that we can offer you and your child a complete and informative visit. After the packet is reviewed, someone from our staff will call you to schedule an appointment. Please note, it is the nature of our practice to provide each client with individualized care and it is not unusual for appointment times to last from 1 ½ to 2 hours.

The Authorization for Use or Disclosure of Health Information form has been provided to assist you in obtaining any medical records on your child. Please make copies and send the form to the private physicians and/or hospitals that have been involved in the care of the patient. Medical records contain very private information and legally, only you can authorize for them to be sent to other doctors or hospitals for review. It is your responsibility to obtain the necessary medical records.

If your insurance is an **HMO**, you must obtain authorization from the primary doctor **before** the appointment can be scheduled. If your insurance is a **PPO**, it is suggested that you contact your insurance provider to determine if an authorization is needed for a Genetics evaluation to avoid being billed. Co-payments are collected at the time of check-in to the clinic. **Please bring your insurance card and authorization letter (if applicable) with you to the appointment.** Please notify us immediately if insurance authorization is denied. You can contact us if you need additional assistance.

Sincerely,

Tami Kendra, Clinic Coordinator  
Cedars-Sinai Medical Center  
Medical Genetics Institute  
Phone: 310-423-9914  
Fax: 310-423-2080

## MEDICAL GENETICS - PEDIATRICS

Date:	Expected DOS:
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**PATIENT INFORMATION:**

Name:	DOB:	Sex:	MRN:
Address:		City, State, Zip Code:	
Mother's Maiden Name:		Race:	Birthplace:
Home #:	Social Security No:		Religion:
Emergency Contact:	Relationship:	Phone:	

**PARENT/GUARDIAN OR NEAREST RELATIVE INFORMATION:**

Mother's Name:	Soc Sec. No.	Race:
Employer:	Occupation:	DOB:
Phone:	Employ. Address:	
Father's Name:	Soc. Sec. No:	Race:
Employer:	Occupation:	DOB:
Phone:	Employ. Address:	

**PRIMARY CARE PHYSICIAN INFORMATION:**

Physician:	Contact:
Address:	City, State:
Phone:	Fax:

**REFERRING PHYSICIAN INFORMATION [If Different from Primary Care Physician]:**

Physician:	Contact:
Address:	City, State, Zip:
Phone:	Fax:

**INSURANCE INFORMATION: (circle one) PPO HMO POS EPO**

Insurance Name:		Phone #	
		Medical Group Phone#	
Address:		City, State, Zip:	
Subscriber:	ID #:	Group #:	
Plan#:	Effective:		Co-Pay: \$
Diagnosis:		Medications:	
COMMENTS/NOTES			

**THIS FORM MUST BE FILLED  
OUT COMPLETELY.  
THANK YOU**



Cedars-Sinai Medical Center  
 Medical Genetics Birth Defects Center

**NEW PATIENT QUESTIONNAIRE**

**SECTION ONE: Patient Information – Please Answer ALL Questions**

<b>Patient's Name:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
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<b>Mother's Name:</b>	<b>Father's Name:</b>
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Are both of the above the natural parents?  Yes  No

Married  Separated  Divorced  Single  Other \_\_\_\_\_

<b>Referring M.D.</b>	Phone Number ( )
Address	Fax Number ( )

<b>Primary M.D.</b>	Phone Number ( )
Address	Fax Number ( )

**Briefly describe the nature of your child's problem(s) and what you hope to gain from this appointment.**

**Please list all physicians involved in your child's care:**

Name	Phone #	Specialty	Last & Next Visit



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**NEW PATIENT QUESTIONNAIRE**

**SECTION TWO: (Part A) Prenatal History**

**What prenatal testing did you have?**

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> AFP or "Triple Screen" | <input type="checkbox"/> Glucose (sugar) Test          | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Amniocentesis          | <input type="checkbox"/> CVS Chorionic Villus Sampling | <input type="checkbox"/> Other      |

**Please describe any abnormal results:** \_\_\_\_\_

\_\_\_\_\_

**Which of the following applied to your pregnancy?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chronic Illness          | <input type="checkbox"/> Tobacco Use           | <input type="checkbox"/> Prenatal Vitamins |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Drug Use              | <input type="checkbox"/> Fever             |
| <input type="checkbox"/> Infection                | <input type="checkbox"/> Alcohol consumption   | <input type="checkbox"/> Folic Acid Use    |
| <input type="checkbox"/> Bleeding                 | <input type="checkbox"/> Exposure to Chemicals | before conception/<br>or during pregnancy  |
| <input type="checkbox"/> Abnormal fetal movements | <input type="checkbox"/> Use of medication     | <input type="checkbox"/> Other             |
|   | <input type="checkbox"/> Exposure to X-Rays    |  |

**Please explain any that you have checked:** \_\_\_\_\_

\_\_\_\_\_

**Birth History:**

Length of Pregnancy: \_\_\_\_\_ Delivery Type:  Vaginal  C-Section

Birth Length: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Head Circumference \_\_\_\_\_

Presentation:  Head First  Bottom First  Other \_\_\_\_\_

Hospital: \_\_\_\_\_ Apgar Scores (if known) \_\_\_\_\_

Length of stay in nursery: \_\_\_\_\_

Birth Complications, if any: \_\_\_\_\_



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**NEW PATIENT QUESTIONNAIRE**

**SECTION TWO: (Part B) Medical History**

**What studies have been performed on your child?**

**Copies of these reports/imaging must be forwarded to our office prior to any appointment.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> X-Rays                  | <input type="checkbox"/> Chromosome Analysis          | <input type="checkbox"/> Eye/Vision Exam          |
| <input type="checkbox"/> CT Scan/MRI             | <input type="checkbox"/> Specialized Genetics Studies | <input type="checkbox"/> Hearing Evaluation       |
| <input type="checkbox"/> Ultrasound              | <input type="checkbox"/> Other Bloodwork              | <input type="checkbox"/> Developmental Assessment |
| <input type="checkbox"/> EEG                     | <input type="checkbox"/> Skin or Organ Biopsy         |   |
| <input type="checkbox"/> EKG (electrocardiogram) |   |   |
| <input type="checkbox"/> Echocardiogram          |   |   |
| <input type="checkbox"/> Other Studies _____     |   |   |

**Please list any medications that your child is currently taking.**

Name of Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you feel that your child is developing normally?**  Yes  No

**Does your doctor feel that your child is developing normally?**  Yes  No

**If no, please explain:** \_\_\_\_\_  
 \_\_\_\_\_

**What grade is your child in?** \_\_\_\_\_

- Regular Classes       Special Education       Adaptive PE

**Has your child been referred to a Regional Center?**  Yes  No

**Which Center?** \_\_\_\_\_

**Has your child been referred to CCS?**  Yes  No



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**NEW PATIENT QUESTIONNAIRE**

**SECTION TWO: (Part B) Medical History (con't)**

**Please check any of the following that apply to your child's medical history.**

**General:**     Fever         Chills         Sweats         Fatigue  
 Change in Weight     Change in Height     Hospitalizations/Surgeries  
 Temperature Sensitivity     Surgeries     Significant Illnesses  
 Chronic Medical Issues     Birth Defects

**Behavioral:**     Speech Delay         Motor Delays         ADHD/ADD  
 Feeding Difficulties         Sleeping Problems     Behavior Problems  
 Learning Disability

**Therapy:**     Physical Therapy     Occupational Therapy  
 Infant Stimulation         Speech Therapy     Other \_\_\_\_\_

**Skin:**         Rashes         Easy Bruising         Eczema     Lumps  
 Birthmarks     Skin Disorder         Nail Changes

**Head:**         Headaches

**Eyes:**         Redness         Discharge         Change in vision  
 Glaucoma     Cataracts         Eyeglasses         Sensitivity to light  
 Droopy Eyelids     Crossed eyes (Strabismus)     Color Blind

**Ears:**         Infections         Ringing         Hearing Problems  
 Deafness

**Nose:**         Bleeding     Allergies         High frequency of "colds"

**Mouth:**         Teeth Problems     Gum Problems     Unusual voice  
 Cleft Lip/Palate

**Neck:**         Lumps         Pain         Thyroid issues

**Chest:**         Cough         Pain         Respiratory problems  
 Asthma     Wheezing         Pneumonia         Snoring  
 Apnea     Restlessness (Frequent waking while sleeping)

**Heart:**         Palpitations         Shortness of breath with exertion  
 Heart murmur     Abnormal blood pressure



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**NEW PATIENT QUESTIONNAIRE**

**SECTION TWO: (Part B) Medical History (con't)**

<b>Digestive:</b>	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Excessive thirst
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Constipation
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Stomach aches	<input type="checkbox"/> Liver disease
			<input type="checkbox"/> Diarrhea
			<input type="checkbox"/> Reflux
			<input type="checkbox"/> Food intolerance
<b>Urinary:</b>	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine
	<input type="checkbox"/> Bed-Wetting	<input type="checkbox"/> Strong or unusual odor of urine	<input type="checkbox"/> Unusual color of urine
	<input type="checkbox"/> Infections		
<b>Muscle/ Bone:</b>	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cramps	<input type="checkbox"/> Stiffness
	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Limitation of movement	
<b>Neurologic:</b>	<input type="checkbox"/> Fainting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness
	<input type="checkbox"/> Tremors	<input type="checkbox"/> Tics	<input type="checkbox"/> Seizures
		<input type="checkbox"/> Unsteady Gait	<input type="checkbox"/> Tingling
			<input type="checkbox"/> Mood changes

**SECTION THREE: Family History**

**Mother's History:**  
 Date of birth \_\_\_\_\_ # of Pregnancies \_\_\_\_\_ # of Livebirths \_\_\_\_\_  
 Height \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Stillbirths \_\_\_\_\_

**Please list any medical problems/medications:** \_\_\_\_\_  
 \_\_\_\_\_

**Father's History:**  
 Date of birth \_\_\_\_\_ Height \_\_\_\_\_

**Please list any medical problems/medications:** \_\_\_\_\_  
 \_\_\_\_\_

**Are the patient's mother and father related? (for example, cousins)**  
 Yes       No       Possibly



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**NEW PATIENT QUESTIONNAIRE**

**SECTION THREE: Family History (con't)**

**List patient's brothers and sisters: (If half sibling's, please note maternal or paternal)**

A-Alive D-Deceased

Name	Age	Sex	Health Problems	A/D	Full or half sibling

**List mother's brothers and sisters: (If half sibling's, please note maternal or paternal)**

A-Alive D-Deceased

Name	Age	Sex	Health Problems	A/D	Full or half sibling

**List father's brothers and sisters: (If half sibling's, please note maternal or paternal)**

A-Alive D-Deceased

Name	Age	Sex	Health Problems	A/D	Full or half sibling



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**NEW PATIENT QUESTIONNAIRE**

**SECTION THREE: Family History (con't)**

<b>Grandparent's information:</b> A-Alive D-Deceased				
Name	A/D	Age	Ethnic Background	Health Problems
<b>Maternal Grandmother</b>				
<b>Maternal Grandfather</b>				
<b>Paternal Grandmother</b>				
<b>Paternal Grandfather</b>				

**Is there a family history of ...?**

Miscarriages                       Mental Retardation                       Unusual Appearance  
 Stillbirths                               Learning Disorders/  
 Infertility                                      Developmental Delay                       Cancer  
 Birth Defects                               Autism                                       Psychiatric Disorder  
 Newborn/Childhood deaths  
 Other disease, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**This form was filled out by:** \_\_\_\_\_

**Date:** \_\_\_\_\_



CEDARS-SINAI MEDICAL CENTER.

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Persons/Organizations authorized to use or disclose the information: <sup>1</sup> \_\_\_\_\_

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number): \_\_\_\_\_

This Authorization applies to the following information (select only one of the following): <sup>2</sup>

- A.  All health information pertaining to any medical history, mental or physical condition and treatment received.  
     [Optional] Except: \_\_\_\_\_
- Only the following records or types of health information (including any dates): \_\_\_\_\_

B. I specifically authorize release of the following information (check as appropriate): <sup>2,3</sup>

- Mental Health treatment information
- HIV test results
- Alcohol / Drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

**PURPOSE**

Purpose of requested use or disclosure: <sup>4</sup>  Patient request; **OR**  Other: \_\_\_\_\_

**EXPIRATION**

This Authorization expires (not to exceed 24 months): <sup>5</sup> \_\_\_\_\_  
(Insert Date or Event)

**NOTICE OF RIGHTS AND OTHER INFORMATION**

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization. <sup>6</sup>
- Neither **treatment, payment, enrollment nor eligibility** for benefits will be conditioned on my providing or refusing to provide this authorization. <sup>7</sup>
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless

unless such disclosure is specifically required or permitted by law.

- I may inspect or obtain a copy of the health information that I am being asked to use or disclose. If this box  is checked, the Requestor will receive compensation for the use or disclosure of my information.

### SIGNATURE

Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Signature: \_\_\_\_\_

*(Patient / Representative / Spouse / Financially Responsible Party)*

If signed by someone other than the patient, state your legal relationship to the patient: <sup>8</sup> \_\_\_\_\_

Witness: \_\_\_\_\_

Hospital Representative Processing Request: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature)

- <sup>1</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
- <sup>2</sup> This form may **not** be used to release both psychotherapy notes and other types of health information (see 45 CFR“164.508 (b)(3)(ii)). If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. An authorization for use or disclosure of HIV test results must **specifically** state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.
- <sup>3</sup> If mental health information covered by Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master’s degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons there-fore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party.
- <sup>4</sup> The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- <sup>5</sup> If authorization is for the use or disclosure of protected health information for research, including the creation and main-tenance of a research database or repository, the statement “end of research study”, “None”, or similar language is suf-ficient.
- <sup>6</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a cov-ered entity for its own uses and disclosures (see 45 CFR“164.508 (d)(1), (e) (2)).
- <sup>7</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condi-tion treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as fol-lows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. Under no circum-stances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
- <sup>8</sup> The requestor is to complete this section of the form.

**Reference:** Welfare and Institutions Code Section 5328.7