Advanced Women's Health
OB/GYN

ROUTINE SCREENING
DURING PREGNANCY

Patient's Name: ______________________________ Date: ________________

Date of Birth: ______________

Congrats on your pregnancy! Advanced Women's Health would like to inform you of the routine testing that are provided during your pregnancy.

These tests include:

1.) PAP Smear, Gonorrhea, Chlamydia and Trichomonas

2.) Routine Pregnancy Panel which includes lab work for:

- Blood Type & Antibody Screen
- Rubella & Varicella
- Cystic Fibrosis
- TSH, CBC, RPR
- HIV, HEP, BMP

3.) Urine Culture & Sensitivity

4.) Urine Drug Screening

5.) Gestational Diabetes

6.) GBS

By signing my name below, I hereby acknowledge that these tests will be collected during my pregnancy. I understand that by signing below, I am allowing these tests to be collected. I also understand that I may discuss any questions regarding these test with my doctor.

______________________________ Date: ________________

Signature of Patient/Guardian