Down Syndrome Test Form

Patient Information

Name: John Smith

Date of Birth: 02/15/1980

Gender:

☐ Male

☑ Female

Contact Number: (555) 123-4567

Address: 123 Oak Street

City/State/ZIP: Anytown, CA 98765

Email Address: john.smith@email.com

Patient ID/Record Number: 789456

Medical History

Existing Medical Conditions (if any): None

Current Medications: None

Allergies: None

Previous Surgeries or Medical Procedures: Appendectomy in 2005

Risk Assessment

Are there any family members with a history of Down syndrome?

☑ Yes

☐ No

If yes, please provide details:

If yes, please provide details: John's cousin, Sarah, has Down syndrome.

Have there been any abnormal prenatal screening results?

☐ Yes

☑ No

If yes, please provide details:

Are there any concerns or symptoms related to Down syndrome in the patient?

☐ Yes

☑ No

If yes, please provide details:

Provider Information

Healthcare Provider's Name: Dr. Emily Johnson

Clinic/Hospital Name: ABC Family Clinic

Clinic/Hospital Address: 456 Elm Avenue, Anytown, CA 98765

Phone Number: (555) 789-1234

Email Address: emily.johnson@abcfamilyclinic.com

Declaration

I, the undersigned, certify that the information provided in this Down Syndrome Test Form is accurate and complete to the best of my knowledge. I understand that this information is essential for assessing the risk of Down syndrome and ensuring appropriate medical care.

Patient's Signature: John Smith

Date: 10/09/2023

Healthcare Provider's Signature: Dr. Emily Johnson

Date: 10/09/2023