



## **Cathy J. Berry, MD and Associates**

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### **OB QUESTIONNAIRE FORM**

1. Dr. Cathy J. Berry, MD & Associates. Providers function as a group and you may be seen and cared for by any of the practices health care providers (physicians, certified nurse practitioners, nursing staff). The health care providers are both male and female and of various racial and ethnic origins.

Do you accept that you will be cared for by any of our providers? Yes  No

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2. The use of illegal and / or narcotic street drugs (for example, cocaine, marijuana, heroin, etc.) during pregnancy is a distinct threat to the health of both the mother and her unborn child. Dr. Cathy J. Berry, MD & Associates is requesting that maternity patients give us permission to perform random screening for such drugs during their pregnancy both in the office and at Crouse Hospital. For us to do this you must give your permission. You may refuse permission, and this refusal will not affect your prenatal care.

I give permission for drug screening during my pregnancy. Yes  No

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3. I understand that if I am in need of a referral for community services, including Onondaga County Department of health and Onondaga County Department of Social Services, including public health nurses and / or visiting nurses, the exchange of medical information with agents of those community service(s) will occur.

This will include HIV and HIV related information. Yes  No

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4. I understand that as part of our comprehensive ambulatory care program, the medical record information of myself and my child is shared with Crouse Hospital.

This will include HIV and HIV related information. Yes  No

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5. Dr. Cathy J. Berry, MD & Associates generally follows the recommendations of the American College of Obstetrics and Gynecology as to the type and frequency of tests / procedures scheduled for patients during their pregnancy. The purpose of this is to provide a high level of quality medical care.

I understand that while a patient has the right to refuse any test and / or procedures, a signed written refusal in the medical record will be required. Yes  No

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6. Do you have religious or other personal restrictions on any form of medical treatment, including blood transfusions? Yes  No
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7. Have you read and understood all of the above and have all of your questions been answered to your complete satisfaction? Yes  No

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date