



OHSU Clinical Genetics Laboratories

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Biochemical Genetics Laboratory

TAY-SACHS SCREENING AND PREVENTION PROGRAM

Certified Center, International Tay-Sachs Disease Carrier Testing Program

Confidential Questionnaire

Name: Birth date:

Home address: Home phone:

City/State/ZIP code: Work phone:

Social Security #: Spouse Name:

- 1. Are you of Jewish ancestry?
2. Is your spouse of Jewish ancestry?
3. If female, are you currently pregnant?
4. If male, is your spouse currently pregnant?
5. If you answered YES to either #3 or #4, enter number of weeks:
6. Has Tay-Sachs disease ever occurred in a blood relative?
7. If you answered YES to #6, please list details (i.e., relationship, where, when):

- 8. Has a blood relative been diagnosed as a Tay-Sachs (or Sandhoff) Disease Carrier?
9. If you answered YES to #8, please list details (i.e., relationship, where, when):

- 10. If female, are you currently taking oral birth control medication?
11. Are you currently on any medication (including over the counter remedies)?
12. If you answered YES to #11, please list medications:

- 13. Have you had a serious illness during the past three months (such as mononucleosis, hepatitis) or other illness requiring long-term doctors care or hospitalization?
14. If you answered YES to #13, please specify illness:

If you want your private physician and/or your spouse's private physician to receive a copy of your screening results, please fill in the following information:

Physician Name: Phone:
Clinic/Address:
City/State/Zip:

I hereby consent to having a blood specimen drawn from me to determine if I carry the gene for Tay-Sachs or related disorders. I understand that all the information I have hereby provided, as well as the results of my screening, will be handled confidentially and that this information will be used for statistical reporting purposes only.

Signature: Date:

NOTE: This form must accompany any request for Tay-Sachs (or related disorders) carrier testing