

Prader-Willi Syndrome Assisted Reproduction Study

ID# _____ Age: _____ Name (optional): _____

Please answer all questions below. If you need to explain or add information, please use the back of this page.

1. Age of mother at time of birth of the baby with PWS? _____
2. Age of father at time of birth of the baby with PWS? _____
3. Genetic subtype:
 - a. standard deletion _____
 - b. UPD _____
 - c. imprinting defect? _____
4. Do you know the type of genetic test or tests used to obtain the answer in #3? Yes _____ No _____.
If Yes, please list all the testing done to establish the genetic subtype:

5. Type of assisted reproduction:
 - a. hormonal stimulation only _____
 - b. IVF [in vitro fertilization] _____
 - c. ICSI [intracytoplasmic sperm injection] _____
 - d. Artificial insemination _____
 - e. Other _____What was the name and location (city and state) of the clinic where the assisted reproduction was performed?

6. Number, ages and sex of other children? _____

7. Is your child with PWS a twin? Yes ___ No _____.
If yes, identical _____ or fraternal? _____
8. Past history of miscarriage and number? _____
9. Would you be willing to be contacted by PWSA (USA) with informed consent form and buccal swab kit (to swab the inside of your cheek) for isolation of DNA from the mother and/or child (with PWS), if a relevant study was proposed and/or to confirm genetic testing if necessary? Yes _____
No _____
10. Do you live in the USA? Yes _____ No _____
If not, what country? _____

Thank you!

Return to: PWSA (USA), 8588 Potter Park Dr. Suite 500, Sarasota, FL 34238