Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Medical Record Number: [Insert MRN]

Dear [Patient Name],

This letter summarizes our genetic counseling discussion on [Date of Visit] regarding prenatal screening and testing options for your current pregnancy.

Reason for Consultation:
[Insert Reason, e.g., Advanced Maternal Age, Abnormal Ultrasound, Family History, or Routine Information]

Topics Discussed:

- **Screening Tests:** We discussed non-invasive options such as Cell-Free DNA (NIPT) and Maternal Serum Screening. These tests estimate the risk for conditions like Trisomy 21 (Down syndrome), Trisomy 18, and Trisomy 13, but they do not provide a definitive diagnosis.
- **Diagnostic Tests:** We discussed invasive procedures, including Chorionic Villus Sampling (CVS) and Amniocentesis. These tests can provide a definitive "yes" or "no" answer regarding chromosomal abnormalities but carry a small risk of pregnancy loss.
- **Carrier Screening:** We reviewed options for testing the parents to determine if they carry genes for recessive conditions such as Cystic Fibrosis, Spinal Muscular Atrophy, or Sickle Cell Anemia.

Summary of Decisions:
Based on our discussion, you have elected to proceed with: [Insert Selected Test or "Declined All Testing"].

Next Steps:
[Insert Follow-up Instructions, e.g., Blood draw today, Schedule ultrasound, or Await results in 7-10 days].

Please remember that genetic testing is voluntary. If you have any further questions or if your family history changes, please contact our office at [Insert Phone Number].

Sincerely,

[Counselor Name/Signature]
[Title/Credentials]
[Clinic Name]