

Spina Bifida & Neural Tube Defects Questionnaire

Claims Administrator:
 Consociate • Dansig
 Attn: Underwriting
 111 E. Decatur Street, P.O. Box 1068
 Decatur, IL 62525
 Phone: (888) 242-4357
 Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. Name of condition _____

2. Is there any physical disability or mental retardation? Yes or No If yes, please explain: _____

3. Is there any hydrocephalus (water on the brain)? Yes or No _____
 If yes, was a shunt placed? Yes or No _____
 Is the shunt still in place? Yes or No _____
 Functioning? _____

4. Is there any anencephaly? Yes or No If yes, is the brain partially/completely absent? _____

5. Have any tests been done? Yes or No If yes, give test date and results: _____

6. What treatment(s) was received and when? Include any surgery, hospital stays, and medication: _____

Medication name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. How often does the person visit the Doctor's office or medical clinic for this condition
 When was the last time and what was the result? _____

8. Have future tests, surgery or treatment been scheduled, prescribed or recommended?
 If yes, please explain: _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

