

MATERNAL SERUM TESTING PATIENT HISTORY

Client ID: _____ Specimen Collection Date: _____

Patient Name: _____ Date of Birth: _____

Physician/Genetic Counselor: _____ Physician/Genetic Counselor Phone: _____

TEST ORDER

Maternal Serum Screen, First Trimester, hCG, PAPP-A, NT (MATFIR)

REQUIRED PATIENT INFORMATION

Patient's weight: _____ lbs.

Due date (ECD):

Determined by: Last menstrual period, confirmed by ultrasound Ultrasound Last menstrual period: _____

Number of fetuses

Singleton Twins Unknown For twins, check box is pregnancy is monochorionic

Patient's race

Non-Black Black Unknown

Was the patient diabetic at the time of conception?

No Yes

Does the patient currently smoke cigarettes?

No Yes

Has patient taken valproic acid or carbamazepine during this pregnancy?

No Yes

Has the patient had a previous pregnancy with trisomy (i.e., Down syndrome, Trisomy 18 or 13)

No Yes If yes, specify abnormality: _____

Is there a family history of neural tube defects (i.e., spina bifida, anencephaly, encephalocele)?

No Yes If yes, relationship of the affected individual to the fetus: _____

In this an in vitro fertilization pregnancy using a donor egg?

No Yes If yes, age of egg donor: _____ yrs.

Is this a repeat sample?

No Yes Unknown

ADDITIONAL INFORMATION (required)

Ultrasound date: _____

ALL TESTS: Obtain NT when CRL is 38–83.9 mm

Sonographer's name: _____

FMF or NTQR Certification #: _____

Reading MD name: _____

FMF or NTQR Certification #: _____

CRL (mm): _____ NT (mm) _____ If twins: Twin B CRL (mm) _____ Twin B NT (mm) _____

Perform blood draws when CRL is within the appropriate range:

First Trimester: CRL 43–83.9