



The information below is required to perform maternal serum testing.
Please attach paper requisition or include with manifest if you order electronically.

PATIENT HISTORY FOR MATERNAL SERUM TESTING

Client Location: _____	Specimen Collection Date: _____
Patient Last Name _____	First Name _____ MI _____
Date of Birth _____	Phone # _____
Physician/Genetic Counselor _____	
Comments or Special Instructions and DX Code _____	

- | | |
|--|---|
| <input type="checkbox"/> PRS4 (Prenatal Risk Quad Screen)
<i>*Must be drawn between 14 weeks, 0 days and 22 weeks, 6 days</i> | <input type="checkbox"/> MSSFT (Maternal Screen, First Trimester Only)
<i>*Must be drawn in first trimester with a crown rump length between 42mm and 79mm</i> |
| <input type="checkbox"/> MSSS1 (Maternal Screen Sequential, Spec #1, 1st Trim)
<i>*Must be drawn in first trimester with a crown rump length between 42mm - 79mm</i> | <input type="checkbox"/> MSSS2 (Maternal Screen, Sequential, Spec #2, 2nd Trim)
<i>*Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days</i> |
| <input type="checkbox"/> MSSIS1 (Maternal Screen, Integrated Specimen #1)
<i>*Must be drawn in the first trimester with a crown rump length between 36mm and 79mm</i> | <input type="checkbox"/> MSSIS2 (Maternal Screen ,Integrated Specimen #2)
<i>*Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days</i> |
| <input type="checkbox"/> Serum only, NT measurement not done | <input type="checkbox"/> Serum only, NT measurement not done |

REQUIRED PATIENT INFORMATION:

- A. Gestational Age: Weeks _____ Days _____ On (date) _____
Determined by: LMP Date: _____ Ultrasound Date: _____ EDD: _____
- B. Is patient insulin dependent diabetic?
 No Yes
- C. Current weight _____ lbs.
- D. Patient's Race?
 Caucasian Black Hispanic Asian Other
- E. Has the patient had a previous pregnancy with a chromosome abnormality? (Down syndrome, Trisomy 18 or 13)
 No Yes If yes, specify abnormality _____
- F. Is there a family history of neural tube defect?
 No Yes If yes, relationship to fetus? _____
- G. Confirmed number of fetuses in this pregnancy:
 Singleton Twins
- H. Is this an *in vitro* fertilization pregnancy using a DONOR egg?
 No Yes
If yes, date of birth of egg donor _____
- I. Has patient taken valproic acid or carbamazepine during this pregnancy?
 No Yes
If yes, specify drug _____
- J. Is this a repeat sample?
 No Yes

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Sequential, or Integrated Maternal Screen only):

Date of Ultrasound _____ Name of Sonographer _____
 Certification # of Sonographer _____ Reading M.D. _____
 NT (mm) _____ CRL (mm) _____
 If twins: Twin B NT (mm) _____ Twin B CRL (mm) _____
 Check box if pregnancy is monochorionic