

# Warde Medical Laboratory

Physician Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Place SOFT Media  
Label Here

## Prenatal Information Sheet

<input type="checkbox"/> <b>QUAD</b> (15w,0d to 22w,6d) <input type="checkbox"/> <b>MSAFP</b> AFP single marker – NTD only (15w,0d to 22w,6d) <input type="checkbox"/> <b>SI1</b> Serum Integrated Screen Part 1 (10w,0d to 13w,6d) <input type="checkbox"/> <b>SI2</b> Serum integrated Screen Part 2 (15w,0d to 22w,6d)	<b>NT measurement <u>required</u> for the following tests:</b> <input type="checkbox"/> <b>FTS</b> First Trimester Screen (CRL 42 to 79.9 mm) <input type="checkbox"/> <b>SS1</b> Sequential Screen Part 1 (CRL 36 to 79.9 mm) <input type="checkbox"/> <b>SS2</b> Sequential Screen Part 2 (15w,0d to 22w,6d) <input type="checkbox"/> <b>FI1NT</b> Full Integrated Screen Part 1 (CRL 32 to 79.9 mm) <input type="checkbox"/> <b>FI2NT</b> Full Integrated Screen Part 2 (15w,0d to 22w,6d)
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### Section I – Required Patient Information

Please fill out **completely** and send with sample to ensure timely results.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Weight: \_\_\_\_\_ lbs. (Weight is **required** for risk assessment)
- Race:  White  Black  Other
- Insulin Dependent Diabetic?  Yes  No (Select Yes if patient was on insulin **prior** to this pregnancy; otherwise, select No)
- Does the patient currently smoke cigarettes?  Yes  No
- Has the patient had a previous pregnancy/child with a Neural Tube Defect?  Yes  No If yes, when? \_\_\_\_\_
- Has the patient had a previous pregnancy/child with Down syndrome?  Yes  No If yes, at what age? \_\_\_\_\_
- Was there an oocyte donor?  Yes  No If yes, what is the donor's DOB at retrieval? \_\_\_\_\_
- Is this a repeat screen for the **current** pregnancy?  Yes  No

### Section II – QUAD, MSAFP or Serum Integrated Screening

EDD \_\_\_\_/\_\_\_\_/\_\_\_\_ based on  Ultrasound  LMP  Exam DATING IS UNCERTAIN

Note: Ultrasound improves screening performance

Number of Fetuses:  Singleton  Twins  Unknown (Risk estimates are not available for triplets)

### Section III – First Trimester, Full Integrated or Sequential Screening

Date of Ultrasound \_\_\_\_/\_\_\_\_/\_\_\_\_

If Twins:

CRL (mm) \_\_\_\_\_

CRL Twin B (mm) \_\_\_\_\_

NT (mm) \_\_\_\_\_

NT Twin B (mm) \_\_\_\_\_

N.B.  Yes  No  Unable to report

N.B. Twin B  Yes  No  Unable to report

Name or Certification # of Sonographer \_\_\_\_\_

Monochorionic  Dichorionic

Note: Sonographer **must** be certified through either FMF or NTQR.

300 W. Textile Road  
Ann Arbor, MI 48108  
Phone (800)760-9969  
Fax (734) 214-0399

**Please have blood drawn between**

\_\_\_\_/\_\_\_\_/\_\_\_\_ & \_\_\_\_/\_\_\_\_/\_\_\_\_