Warde Medical Laboratory

Physician Name_____
Phone (_____) _____-_____
Fax (_____) _____-_____

Place SOFT Media Label Here

Prenatal Information Sheet

☐ ***QUAD*** (15w,0d to 22w,6d) ☐ ***MSAFP*** AFP single marker – NTD only (15w,0d to 22w,6d) ☐ ***SI1*** Serum Integrated Screen Part 1 (10w,0d to 13w,6d) ☐ ***SI2*** Serum integrated Screen Part 2 (15w,0d to 22w,6d)	**NT measurement *required* for the following tests:** ☐ ***FTS*** First Trimester Screen (CRL 42 to 79.9 mm) ☐ ***SS1*** Sequential Screen Part 1 (CRL 36 to 79.9 mm) ☐ ***SS2*** Sequential Screen Part 2 (15w,0d to 22w,6d) ☐ ***FI1NT*** Full Integrated Screen Part 1 (CRL 32 to 79.9 mm) ☐ ***FI2NT*** Full Integrated Screen Part 2 (15w,0d to 22w,6d)

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 ☐ Hispanic ☐ 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? _____
- Is this an IVF pregnancy? ☐ Yes ☐ No •If yes, were donor eggs used? ☐ Yes ☐ No
  - What is the donor's DOB or age 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 _____/_____/_____

CRL (mm) _____

NT (mm) _____

N.B. ☐ Yes ☐ No ☐ Unable to report

Name or Certification # of Sonographer _____

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

If Twins:

CRL Twin B (mm) _____

NT Twin B (mm) _____

N.B. Twin B ☐ Yes ☐ No ☐ Unable to report

☐ Monochorionic ☐ Dichorionic

300 W. Textile Road
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Please have blood drawn between

_____/_____/_____ **&** _____/_____/_____

Revised 04/15/2020