FTS1 Testing performed between 11 weeks, 0 days to 13 weeks, 6 days

***Requires a nuchal translucency measurement from a sonographer certified through either FMF or NTQR**

Prenatal screening for:

- Trisomy 21 (Down syndrome) and Trisomy 18 (Edwards syndrome)

Patient Name: _____ Date of Birth: _____/_____/_____

1. Physician Phone Number (_____) _____-_____
2. Notes to Laboratory: _____
3. Weight: _____lbs.
4. Race: ☐ White ☐ Black ☐ Hispanic ☐ Other
5. Insulin Dependent Diabetic? ☐ Yes ☐ No (Select Yes if patient was on insulin ***prior*** to this pregnancy; otherwise, select No)
6. Does the patient currently smoke cigarettes? ☐ Yes ☐ No
7. Has the patient had a previous pregnancy/child with a Neural Tube Defect? ☐ Yes ☐ No • If yes, when? _____
8. Has the patient had a previous pregnancy/child with Down syndrome? ☐ Yes ☐ No • If yes, at what age? _____
9. Is this an IVF pregnancy? ☐ Yes ☐ No (The age of the egg affects the risk calculations.)

   If egg donor (other than patient), provide donor birth date _____ or current age _____

10. Date of Ultrasound _____/_____/_____
11. CRL (mm) _____
12. NT (mm) _____
13. Name or Certification # of Sonographer _____
14. N.B. ☐ Yes ☐ No ☐ Unable to report
15. Is this a repeat screen for the ***current*** pregnancy? ☐ Yes ☐ No

If Twins:

16. CRL Twin B (mm) _____
17. NT Twin B (mm) _____
18. ☐ Monochorionic ☐ Dichorionic
19. N.B. Twin B ☐ Yes ☐ No ☐ Unable to report

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