



QUADS Quad Screen

Testing performed between 14 weeks, 0 days to 24 weeks, 6 days

Prenatal screening for open neural tube defect, 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. (Weight is **required** for risk assessment)
4. EDD ____/____/____
5. EDD based on ☐ Ultrasound ☐ LMP
6. Number of Fetuses: ☐ Singleton ☐ Twins
7. Race: ☐ White ☐ Black ☐ Hispanic ☐ Other
8. Insulin Dependent Diabetic? ☐ Yes ☐ No (Select Yes if patient was on insulin **prior** to this pregnancy; otherwise, select No)
9. Does the patient currently smoke cigarettes? ☐ Yes ☐ No
10. Is this a repeat screen for the **current** pregnancy? ☐ Yes ☐ No
11. Has the patient had a previous pregnancy/child with a Neural Tube Defect? ☐ Yes ☐ No • If yes, when? _____
12. Has the patient had a previous pregnancy/child with Down syndrome? ☐ Yes ☐ No • If yes, at what age? _____
13. Is this an IVF pregnancy? ☐ Yes ☐ No

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

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