QUAD1 Quad Screen

Testing performed between 15 weeks, 0 days to 22 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 _____

---

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