

Warde Medical Laboratory

Physician Name _____

Phone (_____) _____ - _____

Fax (_____) _____ - _____

Place SOFT Media
Label Here

Prenatal Information Sheet

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

____/____/____ & ____/____/____