Endeavor Health

Department of Pathology & Laboratory Medicine
Phone 847.570.2780
V. 03/2024

Maternal Serum Screening

Form must be completed to calculate MOM and provide risk interpretation

Ordering Physician: _____

Physician Address: _____ Telephone Number:_____

TEST REQUESTED

AFP QUAD SCREEN (LAB2003) ☐

AFP MATERNAL SERUM (LAB4944) ☐
(ONTD only – does not include Down Syndrome Screen)

Date of Specimen Collection: _____

PATIENT INFORMATION

Patient Name: _____

Maternal Date of Birth: _____

INFORMATION FOR CORRECTION FACTORS

Weight: _____(lbs.) Race: Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Other ☐

Insulin Dependent Diabetic: Yes ☐ No ☐

Multiple Pregnancy (i.e. twins, triplets) Yes ☐ No ☐ Number of Fetuses: _____

First MSAFP screening test for this pregnancy Yes ☐ No ☐ If **No** - Date of previous test: _____

Donor egg mother: Yes ☐ No ☐ If **Yes** – Donor egg mother's age: _____(years)

IVF Pregnancy: Yes ☐ No ☐

Active smoker: Yes ☐ No ☐

Previous pregnancy with Downs Syndrome: Yes ☐ No ☐

Family history of Neural Tube Defect (NTD) Yes ☐ No ☐ If **Yes** – check of one of the following

☐ **First Degree Family History** – either patient or father of the fetus was born with NTD, or patient has had a previous pregnancy where the fetus was affected with NTD

☐ **Second Degree Family History** – one of the parents of the fetus has a sibling or parent born with NTD

☐ **Third Degree Family History** – either parent of the fetus has a distant related family member born with NTD

GESTATION AGE

GA BY (Select One)	Ultrasound ☐	LMP ☐	Physical Exam ☐	EDC/EDD ☐
Date	*		**	
GA (Weeks-Days)				

***Ultrasound (US) - provide date of Ultrasound and GA on that date (Program automatically calculates GA to collection date on report)

****Physical Exam (PE) - provide date of Physician Exam and GA on that date (Program automatically calculates GA to collection date on report)

Laboratory Reports Normal Ranges from 15 through 21 week 6 days Gestation Age