Laboratory Corporation of America

Northshore Evanston Account 12038870

Maternal Serum Screening

Submit additional information when ordering First Trimester testing.

Patient Name:____

Req/CTRL #_________________________ Patient ID: _________________________

Required Information

Patient Weight _________lbs

☐ Yes ☐ No Is patient an insulin dependent diabetic?

\# of Fetuses ☐ 1 ☐ 2 ☐ Other________

Patient Race ☐ Cauc ☐ Hispanic ☐ Black ☐ Asian ☐Amer Ind ☐ Other

☐ Yes ☐ No Is this a donor egg? If yes,
Age of donor at egg retrieval:____years

Clinical History

☐ Yes ☐ No Prior Down Syndrome/ONTD Screen in current Pregnancy? If yes, prior test was:
☐ in 1st Tri ☐ in 2nd Tri ☐ elevated msAFP

☐ Yes ☐ No Family history of NTD?

☐ Yes ☐ No Previous pregnancy with Down Syndrome?

☐ Yes ☐ No Other indications: ____________________

____

Tests With Nuchal Translucency (Required Information)

☑ 017500 1 st Trimester Screen (PAPP-A, hCG, DIA) 3mL GEL

NT MEASUREMENTS

CRL date ____/_____/____ CRL _________._________mm (45.0-84.0) NT __________.__________mm

Twin B, if applicable CRL _________._________mm (45.0-84.0) NT __________.__________mm

Chorionicity: ☐ Mono ☐ DI ☐ Unknown

Sonographer Name+: Last____________________ First________________________________

Sonographer ID #: _________________________ Credentialed by ☐ NTQR ☐ FMF ☐ Other

Site ID#:_________________________________ Reading MD ID #:__________________________

Nasal Bone (NB): ☐ Not Evaluated ☐ Present ☐ Absent NB, twin B: ☐ Present ☐ Absent

If NB data provided, please check YES under “Other Indications” above in Clinical History

-- --*Accessioning Instructions: Enter Nasal Bone data in the AFP comment field*-- --

*Gestational age will be based on CRL data provided for Part 1. Integrated & Sequential Testing options require 2 specimens within a specified period. Part 2 follow-up information will be listed on the Part 1 report.

+ The NT and nasal bone must be performed by a sonographer credentialed by the FMF, NTQR or equivalent entity