

A nonprofit enterprise of the University of Utah and its Department of Pathology

PATIENT HISTORY FOR MATERNAL SERUM TESTING

The information below is required to perform maternal serum testing. For electronic orders only, please fill out and submit with the electronic packing list.

Client Number _____ Specimen Collection Date _____

Patient Name _____ Date of Birth _____

Physician/Genetic Counselor _____ Physician/Genetic Counselor Phone _____

Circle the Maternal Serum Screen test you intend to order.

- | | |
|------------------------------------|--|
| 3000143 Maternal Serum Screen Quad | 3000145 Maternal Serum Screen First Trimester |
| 3000144 Maternal Serum Screen AFP | 3000146 Maternal Serum Screen Sequential, Specimen 1 |
| | 3000147 Maternal Serum Screen Integrated, Specimen 1 |

Required Patient Information

- A. Patient's weight: _____ lbs. (or) _____ kgs.
- B. Due date (EDC): _____
Determined by: Last menstrual period, confirmed by ultrasound Ultrasound Last menstrual period _____
- C. Number of fetuses:
 Singleton Twins Unknown For twins, check box if pregnancy is monochorionic.
- D. Patient's race:
 Non-Black Black Unknown
- E. Was the patient diabetic at the time of conception?
 No Yes
- F. Does the patient currently smoke cigarettes?
 No Yes
- G. Has patient taken valproic acid or carbamazepine during this pregnancy?
 No Yes
- H. Has the patient had a previous pregnancy with trisomy (i.e., Down syndrome, Trisomy 18 or 13)
 No Yes If yes, specify abnormality: _____
- I. Is there a family history of neural tube defects (i.e., spina bifida, anencephaly, encephalocele)?
 No Yes If yes, relationship of the affected individual to the fetus: _____
- J. Is this an in vitro fertilization pregnancy using a donor egg?
 No Yes If yes, age of egg donor: _____ yrs.
- K. Is this a repeat sample?
 No Yes Unknown

Additional Information (required for the First Trimester, Integrated, or Sequential screens only)

Ultrasound date: _____ ALL TESTS: Obtain NT when CRL is 38–83.9 mm
 Sonographer's name: _____ FMF or NTQR Certification #: _____
 Reading MD Name: _____ FMF or NTQR Certification #: _____
 CRL (mm): _____ NT (mm) _____ If twins: Twin B CRL (mm) _____ Twin B NT (mm) _____

Perform blood draws when CRL is within the appropriate range:

Integrated 1:	CRL 32.4–83.9 mm
Sequential 1:	CRL 43–83.9 mm
First Trimester:	CRL 43–83.9 mm

