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

3000144 Maternal Serum Screen AFP

3000145 Maternal Serum Screen First Trimester

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 If yes, specify medication:_____

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?
❒ No ❒ Yes If yes, age of egg donor, if used: _____yrs.

K. Has the patient had a previous maternal serum screen in this pregnancy?
❒ 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

ARUP label