**(PAPP-A) FIRST TRIMESTER/SEQUENTIAL MATERNAL SERUM SCREEN INFORMATION FORM**

Must be sent to laboratory with specimens for Sequential Integrated Screen Part 1 and Sequential Integrated Screen Part 2

**Patient/Physician information:**

Patient’s first name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maternal Weight (lbs):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal DOB (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Collection Date (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is mother insulin-dependant \_\_\_\_Y \_\_\_\_N # of Fetuses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EDD (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EDD determined by: \_\_\_\_Ultrasound \_\_\_\_LMP \_\_\_\_Palpation

Date of Ultrasound (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indications for performing this test:**

\_\_\_\_Routine Screening \_\_\_\_Previous neural tube defects \_\_\_\_Advanced maternal age

\_\_\_\_History of Down Syndrome \_\_\_\_History of Cystic Fibrosis \_\_\_\_Not indicated

\_\_\_\_ Other (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**If this is a repeat specimen, please indicate the reason:**

\_\_\_\_Early Gestational Age \_\_\_\_Elevated Result \_\_\_\_Hemolyzed Sample \_\_\_\_Not Indicated

**Please Specify the patient’s Race:**

\_\_\_\_White/Caucasian \_\_\_\_Black \_\_\_\_Native American \_\_\_\_Asian \_\_\_\_Hispanic

\_\_\_\_Other \_\_\_\_Unknown

**Fetal Information:**

Donor Egg \_\_\_\_Y \_\_\_\_N Donor Age/DOB (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Egg Retrieval (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crown-Rump Length (1st fetus in mm): \_\_\_\_\_\_\_\_\_\_\_\_ Date (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crown Rump Length (2nd fetus in mm):\_\_\_\_\_\_\_\_\_\_\_\_ Date (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nuchal Translucency (1st fetus in mm):\_\_\_\_\_\_\_\_\_\_\_ Nuchal Translucency (2nd fetus in mm):\_\_\_\_\_\_\_\_\_\_\_

Nasal Bone \_\_\_\_Absent \_\_\_\_Present \_\_\_\_Not Applicable \_\_\_\_Not Given

Prior down Syndrome/ONTD screening during current pregnancy: \_\_\_\_Y \_\_\_\_N

Prior First Trimester Testing: \_\_\_\_Y \_\_\_\_N Prior Second Trimester Testing: \_\_\_\_Y \_\_\_\_N

Prior history of neural tube defects: \_\_\_\_Y \_\_\_\_N Prior pregnancy with Down Syndrome: \_\_\_\_Y \_\_\_\_N

Indicate the type of chorionicity if carrying twins: \_\_\_\_Monochorionic \_\_\_\_Dichorionic \_\_\_\_Unknown

**Ultrasonographer Information:**

Ultrasonographer first & last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasonographer ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasonographer credentialed by \_\_\_\_NTQR \_\_\_\_FMF \_\_\_\_OTHER (list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Location ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reading Physician ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_