

**Maternal Screening Form**

Test Needed: □ AFP Screen □ TRIPLE □ QUAD □ PENTA

Patient Name: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Id: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen Collection Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Weight (lbs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated Delivery Date (EDD): \_\_\_\_\_\_\_\_\_\_\_ EDD Determined by (choose one):

* Last menstrual period, Date: \_\_\_\_\_\_\_\_\_
* Ultrasound, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of fetuses: singleton / twin / multiple fetus #\_\_\_\_

Is patient insulin dependent diabetic (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this an □ initial testing or □ repeat specimen (Check One)

Does patient have history of neural tube defects (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have history of Down Syndrome pregnancy (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Donor egg (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Donor egg retrieval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient smoke (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_