A5_148 x 210 mm

Pathkind Labs

Affix Barcode

MATERNAL SERUM SCREEN HISTORY FORM

Patient Name: ..... Sample Collection Date: .....

Address: .....

Contact No: ..... E-mail Id: .....

Name of the Collection Center/Lab: .....

Test Requested: Double Marker/Triple Marker/Quadruple Marker

DOB (DD/MM/YYYY): ..... Weight: ..... Kg LMP (DD/MM/YYYY): .....

Gestational age by Ultrasound (in weeks/days): ..... Date of Ultrasound .....

Nuchal thickness (in mm): ..... CRL (in mm) .....

Nasal bone (Present / Absent): .....

(Attach Copy of Latest Ultrasound)

History:

Patient sample: Initial — If Repeat please provide lab no or copy of report

Smoking: Yes/No — **Previous History of Down Syndrome:** Yes/No

Bleeding or Spotting in Last Two weeks: Yes/No — **Diabetic(On Insulin) Status:** Yes/No

Race: Asian/ Caucasian/African/Others — **Gestation:** Single/Double

IVF: Yes/No (In case of IVF pregnancy fill following details)

Source of egg: Self / Donor

Donor's Date of Birth / Age: ..... (In case if Donor's egg was used)

Age of patient during egg retrieval: ..... (In case if Patient's own egg was used)

History of Previous Pregnancies: ..... **History of Pre Eclampsia:** .....

Dated Signature of Patient: .....

Note: In case of Triplets Maternal Screen Test Cannot be performed.