Quest Diagnostics®

FIRST TRIMESTER/SEQUENTIAL MATERNAL SERUM SCREEN

Critical/required information to calculate/recalculate test:

PATIENT NAME/ACCESSION # _____

Physician Name _____

Maternal DOB _____ **Collection date** _____

Maternal Weight _____ **Estimated date of delivery** _____

Method of Dating _____ **(LMP, US, Phys Exam)** **Maternal Race** _____

Is mother insulin-dependant? _____ **# of Fetuses** _____

Did mother have previous pregnancy with:
Down Syndrome? Y/N **Brief HX:** _____
Open Neural Tube defect? Y/N **Brief HX:**_____

Is egg from a donor? Y/N **Age/DOB of donor** _____

Date of Ultrasound _____ **EDD from CRL** _____

Ultrasonographer's name _____ **NTQR or FMF NT certification ID**_____

Crown-Rump Length _____ **Nuchal Translucency** _____

PLS FAX TO 949-728-4779 or if you have questions, please call 800-642-4657 x4455