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MATERNAL SERUM SCREEN 2 ☐ / 3 ☐ / 4 ☐ REQUISITION FORM
(PLEASE TICK REQUESTED TEST)

Patient's Name : .... **Sample Collection Date**: ....

Lab No. : ....

Tel. No. .... Ref. Doctor's Name . ...

D.O.B.(Day/Month/Year) : ....

L.M.P.(Day/Month/Year) : ....

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

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

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

(Attach photocopy of Nasal Bone (Present / Absent) Ultrasound report) : ....

Weight : ....

Diabetic Status (On Insulin) : No ☐ / Yes ☐

Smoking : No ☐ / Yes ☐

Gestation : Single ☐ / Twins ☐

Race : Asian ☐ / African ☐ Caucasian ☐ Others ☐

IVF : No ☐ / Yes ☐

: If yes - Own eggs ☐ / Donor eggs ☐

If yes (Provide D.O.B. of donor) ☐

Patient sample : Initial ☐ / Repeat ☐ ☐

H/O Neural Tube defect in Previous Pregnancy No ☐ Yes ☐

H/O Trisomy 13/18/21 in Previous Pregnancy No ☐ Yes ☐