



The information below is required to perform maternal serum testing.
Please attach paper requisition or include with manifest if you order electronically.

PATIENT HISTORY FOR MATERNAL SERUM TESTING

Client Location: _____ Specimen Collection Date: _____
 Patient Last Name _____ First Name _____ MI _____
 Date of Birth _____ Phone # _____
 Physician/Genetic Counselor _____
 Comments or Special Instructions and DX Code _____

- PRS4 (Prenatal Risk Quad Screen)
**Must be drawn between 14 weeks, 0 days and 22 weeks, 6 days*
- MSSFT (Maternal Screen, First Trimester Only)
**Must be drawn in first trimester with a crown rump length between 42mm and 79mm*
- MSSS1 (Maternal Screen Sequential, Spec #1, 1st Trim)
**Must be drawn in first trimester with a crown rump length between 42mm - 79mm*
- MSSS2 (Maternal Screen, Sequential, Spec #2, 2nd Trim)
**Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days*
- MSSIS1 (Maternal Screen, Integrated Specimen #1)
**Must be drawn in the first trimester with a crown rump length between 36mm and 79mm*
- MSSIS2 (Maternal Screen, Integrated Specimen #2)
**Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days*

REQUIRED PATIENT INFORMATION:

- A. Gestational Age: Weeks _____ Days _____ On (date) _____
 Determined by: LMP Date: _____ Ultrasound Date: _____ EDD: _____
- B. Is patient insulin dependent diabetic?
 No Yes
- C. Current weight _____ lbs.
- D. Patient's Race?
 Caucasian Black Hispanic Asian Other
- E. Has the patient had a previous pregnancy with a chromosome abnormality? (Down syndrome, Trisomy 18 or 13)
 No Yes If yes, specify abnormality _____
- F. Is there a family history of neural tube defect?
 No Yes If yes, relationship to fetus? _____
- G. Confirmed number of fetuses in this pregnancy:
 Singleton Twins
- H. Is this an *in vitro* fertilization pregnancy using a DONOR egg?
 No Yes
 If yes, date of birth of egg donor _____
- I. Has patient taken valproic acid or carbamazepine during this pregnancy?
 No Yes
 If yes, specify drug _____
- J. Is this a repeat sample?
 No Yes

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Sequential, or Integrated Maternal Screen only):

Date of Ultrasound _____ Name of Sonographer _____
 Certification # of Sonographer _____ Reading M.D. _____
 NT (mm) _____ CRL (mm) _____
 If twins: Twin B NT (mm) _____ Twin B CRL (mm) _____
 Check box if pregnancy is monochorionic