



MATERNAL SERUM TESTING PATIENT INFORMATION

This is not a test request form

Triple Marker Screen Quad Marker Screen AFP Maternal/Open Neural Tube Defect Screening

REQUIRED INFORMATION, Items 1-13

1. Your Medstar Account Number: _____
2. Ordering Physician: _____
3. Date Sample was Drawn: ____ / ____ / _____
4. Patient Last Name: _____ Patient First Name: _____
5. Date of Birth: ____ / ____ / _____
6. Weight: _____ lbs.
7. Race: Asian Black Caucasian Hispanic Native American Oriental
8. Gestational Age: ____ Weeks: ____ Days, as of the following date: ____ / ____ / _____ Determined by:
 ___LMP ___Ultrasound
9. Date of Last Menstrual Period (LPM): ____ / ____ / _____
10. Due Date (EDD): ____ / ____ / _____ Determined By: LMP Ultrasound
11. Does the Patient Have Insulin Dependent Diabetes: Yes No
12. Is this Pregnancy: Singleton Twins Triplets
13. Is this IVF pregnancy? Yes No If yes, donor's date of birth ____ / ____ / _____
14. Is this a repeat of a previous abnormal specimen in this pregnancy: Yes No
15. Is there a Neural Tube Defect family history? Yes No Unk If yes, what was the defect and the relation (ex. Self, Sibling, Offspring)?
16. Is there a Down Syndrome family history? Yes No Unk
17. Does the Patient have a smoking history? Yes No

A maternal serum interpretation cannot be determined on patients with a gestational age of less than 15 weeks, 0 days or more than 20 week, 6 days.

Lab Use Only:

Access#:

Req#:

Hospital#:

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Alpha-Fetoprotein (AFP)