RML
REGIONAL MEDICAL LABORATORY
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PRENATAL DIAGNOSIS INFORMATION FORM
SECOND TRIMESTER

Maternal Serum Screen Risks can only be calculated for gestational ages between 15–22.9 weeks. The optimal collection time is at 16-18 weeks gestation.

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	PATIENT SS#:	DATE OF BIRTH:

PATIENT ADDRESS:	CITY:	STATE:	ZIP CODE:

COLLECTION DATE:	TIME: ☐ A.M. ☐ P.M.	COLLECTED BY:	HOME PHONE:

(IF PATIENT IS MINOR) NAME OF GUARANTOR:	HUSBAND'S NAME:

ORDERING DR. / OFFICE INFORMATION

REFERRING PHYSICIAN:	**PHYSICIAN PERFORMING AMNIOCENTESIS:**
OFFICE ADDRESS:	OFFICE ADDRESS:
OFFICE PHONE:	OFFICE PHONE:
OFFICE FAX:	OFFICE FAX:

PATIENT DEMOGRAPHICS

INSULIN DEPENDENT: ☐ YES ☐ NO	**SINGLE FETUS?** ☐ YES ☐ NO #_____	**RACE OF MOTHER:**	**WEIGHT OF MOTHER:** _____ LBS.	**ESTIMATED DATE OF DELIVERY:** _____/_____/_____
Hx NEURAL TUBE DEFECT: ☐ YES ☐ NO	**Hx DOWNS SYNDROME:** ☐ YES ☐ NO	**DONOR EGG USED ? DONOR AGE or DOB:** ☐ YES ☐ NO _____		**EDD CALCULATED BY:** ☐ LMP ☐ Ultrasound
If YES to NTD or Downs please explain:				**REPEAT SPECIMEN ?** ☐ YES ☐ NO

INDICATION(S) FOR AMNIOCENTESIS:

- ☐ **ADVANCED MATERNAL AGE**
- ☐ **PREVIOUS DOWN SYNDROME**
- ☐ **PREVIOUS NEURAL TUBE DEFECT**
- ☐ **FAMILY HISTORY OF:**
- ☐ **OTHER, SPECIFY:**

DATE OF AMNIOCENTESIS: _____/_____/_____	DATE OF LAST MENSTRAL PERIOD: _____/_____/_____
VOLUME OF AMNIOTIC FLUID OBTAINED: _____mL	ULTRASOUND ESTIMATION OF GESTATIONAL AGE: _____WKS
PROBLEMS AT AMNIOCENTESIS? ☐ YES ☐ NO IF YES, EXPLAIN:	
FIRST 1-2cc AMNIOTIC FLUID DISCARDED ? ☐ YES ☐ NO	

REQUESTED TESTING:

☐	**MAT SCR 1**	**[3622315]**	**Maternal Serum Screen 1 (AFP only) 2 mL (0.2) Serum** [AFP]
☐	**AFP MAT PR**	**[3810900]**	**Maternal Serum Screen 3 (Triple Screen) 2 mL (0.5) Serum** [AFP, hCG, uE3]
☐	**MAT SCR 4**	**[3622300]**	**Maternal Serum Screen 4 (Quad Screen) 2 mL (1) Serum** [AFP, hCG, uE3, Inhibin]
☐	**MAT SCR 5**	**[3622400]**	**Maternal Serum Screen 5 (Penta Screen) 4 mL (1.5) Serum** [AFP, hCG, uE3, Inhibin A, ITA]
	Preferred specimen for Amniotic Fluid testing is Two aliquots 20mL each – Keep at Room Temperature		
☐	**AFP AM FL**	**[3811175]**	**Alpha-Fetoprotein, Amniotic Fluid with Reflex to AchE & Fetal Hgb**
☐	**AFP/CHRM**	**[1003950]**	**Chromosomes + Alpha-Fetoprotein, Amniotic Fluid with Reflex to AchE & Fetal Hgb**
☐	**PRENATFISH**	**[0112985]**	**Prenatal FISH (13,18,21,X,Y) - AneuVysion(R) / Aneuploidy Detection**

COMMENTS:

NOTE: This form must accompany the specimen and RML Requisition to the laboratory.