RML
REGIONAL MEDICAL LABORATORY
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PRENATAL DIAGNOSIS INFORMATION FORM
FIRST TRIMESTER

Maternal Serum Screen, First Trimester is best performed at 9-13 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:	**SINGLE FETUS?**	**RACE OF MOTHER:**	**WEIGHT OF MOTHER:**	**ESTIMATED DATE OF DELIVERY:**
☐ YES ☐ NO	☐ YES ☐ NO #_____		_____ LBS.	_____/_____/_____
Hx NEURAL TUBE DEFECT:	**Hx DOWNS SYNDROME:**	**DONOR EGG USED ? DONOR AGE or DOB:**		**EDD CALCULATED BY:**
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO _____		☐ LMP ☐ Ultrasound
If YES to NTD or Downs please explain:				**REPEAT SPECIMEN ?** ☐ YES ☐ NO

AMNIOCENTESIS INFORMATION:

Ultrasonographer's Name:	Crown Rump Length: mm (Millimeters)	DATE of Ultrasound & Amniocentesis: _____/_____/_____
NTQR- Ultrasonographer's ID#:	Nuchal Translucency: mm (Millimeters)	DATE of Last Menstrual Period: _____/_____/_____
NTQR- Location ID#	EDD from Crown Rump Length: _____/_____/_____	EDD (Estimated Date of Delivery): _____/_____/_____
NTQR- Reading Phys ID#	Twin B Crown Rump Length: mm (Millimeters)	Ultrasound Estimation of Gestational Age: _____WKS
FMF- Ultrasonographer's ID#:	Twin B Nuchal Translucency: mm (Millimeters)	Volume of Amniotic Fluid Obtained: _____mL

INDICATION FOR AMNIOCENTESIS

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

PROBLEMS AT AMNIOCENTESIS? ☐ YES ☐ NO

IF YES, EXPLAIN:

FIRST 1-2cc AMNIOTIC FLUID DISCARDED ? ☐ YES ☐ NO

REQUESTED TESTING

☐	**MAT FIRST [3635275]**	**Maternal Serum Screen – First Trimester [Specimen: 2mL (1mL) Serum, Refrigerated]**
	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 w/ 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.