

Maternal Serum Screening

Submit additional information when ordering AFP Maternal, AFP Tetra, AFP Triple, First Trimester, Integrated or Sequential testing.

Patient Name: _____

Req/CTRL # _____ Patient ID: _____

Required Information

Patient Weight _____ lbs
 Yes **No** Is patient an insulin dependent diabetic?
 # of Fetuses 1 2 Other _____
 Patient Race **C**auc **H**ispanic **B**lack
 Asian Amer **I**nd **O**ther
 Yes **No** Is this a donor egg? If yes, Age of donor at egg retrieval: _____ years

Clinical History

Yes **No** Prior Down Syndrome/ONTD Screen in current Pregnancy? If yes, prior test was:
 in 1st Tri in 2nd Tri elevated msAFP
 Yes **No** Family history of NTD?
 Yes **No** Previous pregnancy with Down Syndrome?
 Yes **No** Other indications: _____

Tests Without Nuchal Translucency (Required Information)

Serum Integrated 1 (PAPP-A) 3mL GEL
 Serum Integrated 2 (AFP, uE3, hCG, DIA) 5mL GEL
 AFP Tetra (AFP, uE3, hCG, DIA) 5mL GEL
 AFP X-tra (AFP, uE3, hCG) 3mL GEL
 msAFP (AFP) 3mL GEL

Gestational Age: _____ wks _____ days On date ____/____/____
 Method: LMP EDC/EDD U/S

Tests With Nuchal Translucency (Required Information)

1st Trimester Screen (PAPP-A, hCG, DIA) 3mL GEL
 Sequential Part 1 (PAPP-A, hCG) 3mL GEL
 Sequential Part 2* (AFP, uE3, hCG, DIA) 5mL GEL
 Integrated Part 1 (PAPP-A) 3mL GEL
 Integrated Part 2* (AFP, uE3, hCG, DIA) 5mL GEL

CRL date ____/____/____ CRL _____ mm (45.0-84.0) NT _____ mm
 Twin B, if applicable CRL _____ mm (45.0-84.0) NT _____ mm

Chorionicity: Mono DI Unknown

Sonographer Name*: Last _____ First _____

Sonographer ID #: _____ Credentialed by NTQR FMF Other

Site ID#: _____ Reading MD ID #: _____

Nasal Bone (NB): Not Evaluated Present Absent NB, twin B: Present Absent

If NB data provided, please check YES under "Other Indications" above in Clinical History

-- --Accessioning Instructions: Enter Nasal Bone data in the AFP comment field-- --

*Gestational age will be based on CRL data provided for Part 1. Integrated & Sequential Testing options require 2 specimens within a specified period. Part 2 follow-up information will be listed on the Part 1 report.

* The NT and nasal bone must be performed by a sonographer credentialed by the FMF, NTQR or equivalent entity

NT MEASUREMENTS