MATERNAL SERUM SCREEN
REQUIRED DATA SHEET

MEADVILLE MEDICAL CENTER LABORATORY

COMPLETE ALL INFORMATION **ACL Acct # 410054**

Missing data will result in specimen processing delays and incorrect calculations.

Patient Name *Last First MI*	Date of Birth	Collection Date
Requesting Physician	Phone #	Fax #

SELECT TEST DESIRED:

- ❒ ONTD Screen – **MSS1** *(15-22 wks)*
- ❒ Quad Screen – **MSS4** *(14-22 wks)*
- ❒ Penta Screen – **MSS5** *(14-22 wks)*
- ❒ Integrated Screen, Part 1 ♦ – **PAPPA1** *(9-13 wks)* (**Test # 16148X**)
- ❒ Integrated Screen, Part 2, – **PAPPA2** *(14-22 wks)* (**Test # 16150X**)

EST'D Date of Delivery: _____

Determined by: ❒ Ultrasound ❒ LMP ❒ Physical Exam

Maternal Weight _____ lbs

Mother's Ethnic Origin:
❒ African American ❒ Asian ❒ Caucasian ❒ Hispanic ❒ Other_____

Number of Fetuses: ❒ One ❒ Two ❒ More than two How many fetuses? _____

Yes	No		
		Patient is an insulin dependent diabetic before pregnancy.	
		Is this a repeat specimen for NTD?	(Repeat testing following a screen positive result for Down Syndrome or Trisomy 18 is **NOT** recommended)
		History of NTD	If Yes,explain
		History of Downs	If yes,explain
		Pregnancy is from a donor egg	If Yes, Age or Date of Birth of Donor

Other Clinical Information

♦ **Additional Information required for 1st Trimester Screen (9-13 weeks) Integrated Screen (Part 1) Only**

Crown Rump Length (CRL) mm	Nuchal Translucency mm	EST'D Date of Delivery from CRL

I have a signed informed consent statement which includes a description of the test and authorizes the reporting of an abnormal result to a diagnostic genetic center. I authorize the testing of this specimen for genetic testing and have informed the patient about the above test(s).

Physician Signature Date