RELIABLE DIAGNOSTIC
LABORATORY NEPAL PVT. LTD.
ISO: 15189:2012 Accredited Pathology Laboratory

Committed To Quality, Consistency & Proficiency...

ACCREDITED ISO 15189:2012 LABORATORY

MATERNAL SCREEN REQUISITION FORM
ENGLISH DATE IS MANDATOY (DAY/MONTH/YEAR)

Sample Collection Date: D | M | Y

☐ **DOUBLE MARKER** (10w+0d to 13w+6d)

☐ **TRIPLE MARKER** (15w+0d to 21w+6d)

☐ **QUADRUPLE MARKER** (15w+0d to 21w+6d)

PATIENT'S NAME: ______________________________

DATE OF BIRTH: D | M | Y

HEIGHT: ________ CM / FT

WEIGHT ________ KG

LMP: D | M | Y

INITIAL ☐

REPEAT ☐

BLOOD GROUP: ________

DIABETIC: YES / NO

SMOKING: YES / NO

Folic Acid Supplement Before Conception : YES / NO

Medication : (YES / NO) If YES, Please Specify:

Gestation: SINGLE

TWINS , If Yes: DICHORIONIC / MONOCHORINIC

Type of Pregnancy: (a.) NORMAL

(b.) IVF (If Yes) : OWN EGG

DONOR EGG

(If Yes,Donor Date Of Birth: D | M | Y

FAMILY HISTORY OF DOWN SYNDROME: YES / NO

Previous pregnancy with chromosomal abnormality: YES / NO

If Yes, TRISOMY: 13 / 18 / 21

NTD (Neural Tube Defect)

Date of Ultrasound: D | M | Y

Gestational Age as per Scan: .... **Weeks** .... **Days**

CRL (in mm).................

NT (in mm).................

Husband Name:

Age:

Nationality:

NOTE: ATTACH PHOTOCOPY OF ULTRASOUND REPORT
(SCAN DATE SHOULD BE OF WITHIN 2 TO 3 DAYS)

Patient's Signature:

FOR LABORATORY USE ONLY:

DOUBLE MARKER	TRIPLE MARKER	QUADRUPLE MARKER
1.) PAPPA	1.) B-HCG	1.) B-HCG
2.) B-HCG	2.) UE3	2.) UE3
	3.) AFP	3.) AFP
		4.) INHIBIN 'A'