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

MATERNAL SCREEN REQUEST FORM

ENGLISH DATE IS MANDATORY (DD/MM/YEAR)

SAMPLE COLLECTION DATE:

☐ DOUBLE MARKER ☐ TRIPLE MARKER ☐ QUADRUPAL MARKER

PATIENT'S NAME: ______________________________ DOB: ____________________

WEIGHT: __________KG LMP: ____________________ INITIAL ☐

HEIGHT: __________ Cm/Ft BLOOD GROUP: REPEAT ☐

Para: Gravida: Diabetic: YES NO Smoking: YES NO

Folic Acid Supplementation Before Conception: YES NO

Medication........(Y/N) If Yes, Please Specify:

Gestation: SINGLE

TWINS, If Yes: DICHORIONIC MONOCHORIONIC

Type of Pregnancy: (a.) NORMAL

(b.) IVF (If Yes): OWN EGGS DONOR EGGS **If Yes: DOB of Donor:** ____________________

Family History of Down's syndrome: YES ☐ NO ☐

TRANSFER DATE: DAYS IN VITRO..............DAYS

Previous pregnancy with chromosomal abnormality: YES NO

If Yes: TRISOMY 21 TRISOMY13/18 NTD

Father's Details: Age: Nationality:

Date of Ultrasound : (SCAN DATE SHOULC BE WITHIN 2 to 3 DAYS)

Gestational Age as per scan:__________week's__________days

EDD:

NT : ____________________ mm CRL: ____________________ mm

1stTrimester (0.1mm to 5.0mm) 1st Trimester (38 mm to 83mm)

(PHOTOCOPY OF THE USG REPORT TO BE ATTACHED)

FOR LABORATORY USE ONLY:

DOUBLE MARER:	TRIPLE MARKER:	QUADRUPLE MARKER:
1) PAPPA ☐	1) B-HCG ☐	1) B-HCG ☐
2) B-HCG ☐	2) UE3 ☐	2) UE3 ☐
	3) AFP ☐	3) AFT ☐
		4) INHIBIN "A" ☐

Sample Acceptability Weeks:

FOR DOUBLE MARKER:	(10w + 0d) to (13 w + 6d)
FOR TRIPLE MARKER:	(15w + 0d) to (21w + 6d)
FOR QUADRUPLE TEST:	(15w + 0d) to (21w + 6d)

Patient's Signature:

CamScanner