



Path Kind 
Labs

Affix Barcode

MATERNAL SERUM SCREEN HISTORY FORM

Patient Name: Sample Collection Date:

Address:

Contact No: E-mail Id:

Name of the Collection Center/Lab:

Test Requested: Double Marker/Triple Marker/Quadruple Marker

DOB (DD/MM/YYYY): Weight: Kg LMP (DD/MM/YYYY):

Gestational age by Ultrasound (in weeks/days): Date of Ultrasound:

Nuchal thickness (in mm): CRL (in mm):

Nasal bone (Present/Absent):

(Attach Copy of Latest Ultrasound) **Gestational age Double marker : 10-13.6 weeks ; Quadruple marker :14-22.6 weeks**

History:

Patient sample: Initial

If Repeat please provide lab no or copy of report

Smoking: Yes/No

Previous History of Down Syndrome: Yes/No

Bleeding or Spotting in Last Two weeks: Yes/No

Diabetic (On Insulin) Status: Yes/No

Race: Asian/Caucasian/African/Others

Gestation: Single/Double

IVF: Yes/No (In case of IVF pregnancy fill following details)

Date of Egg Extraction :

Date of Embryo Transfer :

Source of egg: Self/Donor

Donor's Date of Birth/Age: (In case if Donor's egg was used)

Age of patient during egg retrieval: (In case if Patient's own egg was used)

History of Previous Pregnancies: **History of Pre Eclampsia:**

Referring doctor 's name and mobile number :

Dated Signature of Patient:

Note: In case of Triplets Maternal Screen Test Cannot be performed.