PATHKINDLABS

Affix Barcode

MATERNAL SERUM SCREEN HISTORY FORM

PRE-ECLAMPSIA SCREENING – FMF ACCREDITED
(FOR Gestational age – 11 to 13+6 weeks only)

Patient Name:..... **Sample Collection Date:**.....

Address: .....

Contact No:..... E-mail Id: .....

Nome of the Collection Center/\Ob:.....

DOB (DD/MM/YYYY): ..... **Weight:** .....**Kg** **Height** ……**cm**

LMP (DD/MM/YYYY): .....

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

Left arm Blood Pressure……**Right arm Blood Pressure**……

Nuchal Translucency (in mm).....**CRL (in mm):** .....

Nasal bone: Present/Absent **Uterine Artery Pulsatility Index UTPI)**……
(Attach Copy of Latest Ultrasound)

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 Lost 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)

Source of egg: Self/Donor

Donor's Dote 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: .....

Doted Signature of Patient: .....

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