PathGroup
Physician Centered. Patient Focused.

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Maternal Serum Screen Patient Information Form

First and Second Trimester Prenatal Screening

The information below is required to perform and insure accurate results for maternal serum testing. **This is not test order form and should only be submitted in conjunction with an electronic order. Prior to submitting samples for testing to PathGroup, the name and certification number of the certified sonographer must be provided.**

Account Number: ______________________ Collection Date: ______________________

Patient Name (Last, First, MI): ______________________ Date of Birth: __________

Physician/Genetic Counselor: ______________________ Phone #: ______________________

Check the Maternal Serum Screen Test you intend to order:

- ☐ First Trimester **(FTRSC)**
- ☐ Integrated, Specimen #1 **(MSIS1)**
- ☐ Integrated, Specimen #2 **(MSIS2)**
- ☐ Sequential, Specimen #1 **(MSSS1)**
- ☐ Sequential, Specimen #2 **(MSSS2)**

Patient Information:

Current Maternal Weight: __________ Lbs. Number of Fetus: ☐ Single ☐ Twins ☐ Unknown

Due Date (EDC): __________ Determined By: ☐ LMP, confirmed by US ☐ Ultrasound ☐ LMP

Patient's Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other

At conception, was the patient on medication to control diabetes? ☐ No ☐ Yes

Is there a family history of neural tube defects (i.e. spina bifida, anencephaly, encephalocele)? ☐ No ☐ Yes

If yes, relationship of the affected individual to the fetus? ______________________

Has the patient had a previous pregnancy with a chromosome abnormality (i.e. Down syndrome, Trisomy 18 or 13)?

☐ No ☐ Yes If yes, specify abnormality: ______________________

Is this an *in vitro* fertilization pregnancy using a donor egg? ☐ No ☐ Yes If yes, age of egg donor: __________

Has patient taken valproic acid or carbamazepine during this pregnancy? ☐ No ☐ Yes

If yes, specify drug: ______________________

Is this a repeat sample? ☐ No ☐ Yes ☐ Unknown

Certified Sonographer Information: *(Required for First Trimester, Integrated or Sequential Screens only)*

Date of Ultrasound: ______________________

Name of Sonographer:

____

Certification # of Sonographer: ______________________

NT (mm): __________ CRL (mm): __________

If twins, Twin B NT (mm): __________

Twin B CRL (mm): __________

☐ Check box if pregnancy is monochorionic

All Tests:
NT may be obtained when the CRL is 36-85 mm

Blood Draws:

Integrated -1: CRL 36 – 85 mm
Sequential -1: CRL 42 – 85 mm
1st Trimester: CRL 42 – 85 mm