

# Warde Medical Laboratory

300 W. Textile Road  
Ann Arbor, MI 48108  
Phone (800)760-9969  
Fax (734) 214-0399

Physician Name _____
Phone (_____) _____ - _____
Fax (_____) _____ - _____

## Prenatal Information Sheet

<input type="checkbox"/> <b>QUAD</b> (15w,0d to 22w,6d)	<b>NT measurement <u>required</u> for the following tests:</b>
<input type="checkbox"/> <b>MSAFP</b> AFP single marker – NTD only (15w,0d to 22w,6d)	
<input type="checkbox"/> <b>INT ONE</b> Serum Integrated Part One (10w,0d to 13w,6d)	
<input type="checkbox"/> <b>INT TWO</b> Serum integrated Part Two (15w,0d to 22w,6d)	
<input type="checkbox"/> <b>FTS</b> First Trimester Screen (CRL 42 to 79.9 mm)	
<input type="checkbox"/> <b>SEQ SCR 1</b> Sequential Part One (CRL 36 to 79.9 mm)	
<input type="checkbox"/> <b>INT ONE NT</b> Full Integrated Part One (CRL 32 to 79.9 mm)	
<input type="checkbox"/> <b>INT TWO NT</b> Full Integrated Part Two or Sequential Part Two (15w,0d to 22w,6d)	

### Section I – Required Patient Information

Please fill out completely to ensure timely results and send with sample.

- Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Weight: \_\_\_\_\_ lbs.
  - Race:  Caucasian  Black  Other
  - Insulin Dependent Diabetic?  Yes  No (Select Yes if patient was on insulin prior to this pregnancy; otherwise, select No)
  - Has the patient had a previous pregnancy/child with a Neural Tube Defect?  Yes  No If yes, when? \_\_\_\_\_
  - Has the patient had a previous pregnancy/child with Down syndrome?  Yes  No If yes, when? \_\_\_\_\_
  - Was there an oocyte donor?  Yes  No If yes, what is the donor's DOB or age at retrieval? \_\_\_\_\_
  - Is this a repeat screen for the current pregnancy?  Yes  No

### Section II – QUAD, MSAFP or Serum Integrated Screening

Gestational age determined by (please check only one):

- Ultrasound date \_\_\_\_/\_\_\_\_/\_\_\_\_ weeks \_\_\_\_ days \_\_\_\_  Formal  Bedside
- LMP \_\_\_\_/\_\_\_\_/\_\_\_\_  Certain  Uncertain
- EDD \_\_\_\_/\_\_\_\_/\_\_\_\_ based on  Ultrasound  LMP  Exam

Number of Fetuses:  Singleton  Twins  Unknown (Risk estimates are not available for triplets)

### Section III – First Trimester, Full Integrated or Sequential Screening

Date of Ultrasound ____/____/____	<u>If Twins:</u>
CRL (mm) _____	CRL Twin B (mm) _____
NT (mm) _____	NT Twin B (mm) _____
N.B. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported	N.B. Twin B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not reported
Name or Certification # of Sonographer _____	<input type="checkbox"/> Monochorionic <input type="checkbox"/> Dichorionic

Note: Sonographer must be certified through either FMF or NTQR.

Please have blood drawn between \_\_\_\_/\_\_\_\_/\_\_\_\_ & \_\_\_\_/\_\_\_\_/\_\_\_\_