SSMHealth
St. Mary's Hospital Laboratory - MADISON

Prenatal AFP, Triple & Quad Test Information Form

Patient Name:_____ Patient DOB (mm/dd/yyyy):_____

Collection Date & Time:_____ Physician:_____

Number of Fetuses:	_____
Estimated Due Date:	___/___/_____ (mm/dd/yyyy)
Estimated Due Date determined by:	Ultrasound or LMP or both
History of neural tube defect:	Yes or No
Insulin Dependent:	Yes or No
Mother's Ethnic Origin CIRCLE ONE:	Asian, Caucasian, Black, Hispanic, Other
Repeat Sample:	Yes or No
Weeks of Gestation	_____
Weight (lbs.)	_____
Previous Prenatal Chromosome abnormality:	Yes or No If yes, specify:_____
Donor Egg: Yes or No	If yes, Age of Egg Donor _____yrs.
Has patient taken valproic acid during this pregnancy:	Yes or No
Has patient taken carbamazepine during this pregnancy:	Yes or No
Does the patient currently smoke cigarettes:	Yes or No

Updated: 12/13/16