PRENATAL RISK ASSESSMENT FORM

The following information **must** be obtained from the **physician's office.**

Patient Name: ______________________________________Patient Date of Birth: ____________

Physician: ______________________Physician's office telephone number: ________________

Specimen Draw Date: ____

Race: ____Weight: ___________________________

Is the patient insulin dependent? Yes _________ No ___________

Multiple Gestation? Yes ______________ No _________________

If Yes, number of fetuses? ________________

Initial screening or repeat sample? Initial ________ Repeat _________

Family history of neural tube defect? Yes _________ No _________

If Yes, relationship of the affected individual to the fetus?____________

Does the patient currently smoke cigarettes? Yes _________ No _________

Is the patient undergoing in vitro fertilization (IVF)? Yes _________ No _________

If Yes, what is the patient's current IVF status? _________________________________

GESTATIONAL AGE:

Three choices are available to determine Gestational Age.

1. Ultrasound

   If the patient had an ultrasound, please provide the **date of the ultrasound**

   & the **gestational age** on that date. (This can be found on the ultrasound report.)

   Date of ultrasound: ___________

   Gestational age **on the date of the ultrasound**: _____Weeks _____Days

2. LMP (Month-**DAY-**Year): _____________

3. EDD: ___________ Is the EDD based on an ultrasound? Yes___ No ____

   Note: Unless selected, our program will automatically calculate the Gestational Age first by ultrasound, second by LMP if the ultrasound information is not given or third by EDD if US and LMP are not given.

   Please select the desired calculation method: US____ LMP____ EDD____