Place Label Here

PRENATAL RISK ASSESSMENT FORM

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

Patient Name____ **Date of Birth**___________________________

Physician____ **Specimen Collection Date**_______________________

Patient's weight ____________**lbs** OR ____________**kgs** **Physician Phone**_____________________________

Due date (EDC)__________________________________ **Determined by:**

____ last mentral period, confirmed by ultrasound

____ last mentral period. Date:___________________

____ ultrasound

Number of fetuses?

_____Singleton _____Twins _____Unknown

For twins, is pregnancy monochorionic? ____No _____Yes ____ Unknown

Patient's race?

_____Non-Black _____Black _____Unknown

Was the patient diabetic at the time of conception?

_____No _____Yes

Does the patient currently smoke cigarettes?

_____No _____Yes

Has the patient taken valproic acid or carbamazepine during this pregnancy?

_____No _____Yes; specify medication:_____________________________________

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

_____No _____Yes; specify abnormality:_____________________________________

Is there a family history of neural tube defects? (i.e., spina bifida, anencephaly, encephalocele)

_____No _____Yes; specify the relationship of the affected individual to the fetus:________________________

Is this an in vitro fertilization preganancy?

_____No _____Yes; specify the age of the egg donor, if used:______________years

Has the patient had a previous maternal serum screen in this pregnancy?

_____No _____Yes _____Uknown