

BayCare Maternal Testing Information Form

(to be completed by ordering clinician)

Patient Name (Last, First): _____

Patient Date of Birth: _____

Collection Date: _____

For maternal tests listed below:

- Maternal Genetic (SENDOUT)
- 1st Trimester Screen (SENDOUT)
- AFP1 Maternal Screen (SENDOUT)
- AFP4 Maternal Screen (SENDOUT)
- AFP5 Penta Maternal Screen (SENDOUT)
- Sequential 1 Maternal Screen (SENDOUT)
- Sequential 2 Maternal Screen (SENDOUT)

Please complete the following information and send with original request for patient collection:

Maternal Weight (lbs, oz) _____

Maternal Height (ft, in.) _____

Last Menstrual Period (LMP date) _____

Mother's Ethnic Origin _____

Intellectual and Developmental Disabilities _____

Number of Fetuses _____

Other Indications AFP _____

Additional Maternal Info _____

Previous Elevated AFP _____

US Crown Length Rump (mm) _____

US Crown Length Rump date _____

Nuchal Translucency (mm) _____

Nuchal Translucency Twin (mm) _____

Donor Egg _____

Donor Age: Egg Retrieval _____

Type of Egg Donor _____

Prior DownSynd/Open Neural Tube Defects Screen _____

Gestation Age (weeks, days) _____

Personal/Fam HX? _____

Opt out microdels (Y/N) _____

Opt out fetal sex (Y/N) _____

Prior 1st Trimester Test _____

Prior 2nd Trimester Test _____

Family History Neural Tube Defects _____

Prior Pregnancy with Downs _____

Chorionicity (Twins Only) _____

Sonographer Last, First name _____

Sonographer ID Number _____

Credentialed by _____

Site Number _____

Reading Physician ID _____

Insulin Dependent _____

Estimated Date of Delivery/Date of

Confinement _____

EDD Determined by:

Ultrasound _____

Last Menstrual Period (LMP) _____

Physical Exam _____

Abnormal MSS (Y/N)? _____

Abnormal US (Y/N)? _____

