

LM-OrT-FR-019

PRENATAL SCREENING TESTS INFORMATION FORM

Choose one of the tests below:

- | | |
|--|--|
| <input type="checkbox"/> 1st Trimester Down Syndrome Screening Test-Combination Test (Double Test) | <input type="checkbox"/> Down Syndrome Screening Test, Integrated Test |
| <input type="checkbox"/> 2nd Trimester Down Syndrome Screening Test (Triple Test) | <input type="checkbox"/> Alpha Fetoprotein (AFP), Maternal Serum |
| <input type="checkbox"/> 2nd Trimester Down Syndrome Screening Test (Quadruple Test) | <input type="checkbox"/> Alpha Fetoprotein (AFP), Amniotic Fluid |

Please fill in all parts in order to correct risk calculation.

PERSONAL DATA				
Name, Surname:				
Reference No:				
Race:	<input type="checkbox"/> White		<input type="checkbox"/> Black	
Smoking	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Insulin Dependent DM:	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
BirthDate:	/...../.....		
Number of Pregnancy:				
Last Menstrual Date:	/...../.....		
Maternal Weight:	kg		
Ultrasonography Date:	/...../.....		
Sampling Date:	/...../.....		

Number of Fetus	<input type="checkbox"/> Single		<input type="checkbox"/> Twin		➔	<input type="checkbox"/> Monochorionic, Monoamniotic			
IVF	<input type="checkbox"/> Yes		<input type="checkbox"/> No			<input type="checkbox"/> Monochorionic, Diamniotic			
Nasal Bone	<input type="checkbox"/> Present		<input type="checkbox"/> Absent		➔	<input type="checkbox"/> Dichorionic, Diamniotic			
	<input type="checkbox"/> Not evaluated								
NTD in previous pregnancies?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		➔	Trisomy 21		Trisomy 18	
Chromosome anomalies in previous pregnancies?	<input type="checkbox"/> No		<input type="checkbox"/> Yes			Trisomy 13		Other	

For 1st Trimester;			
CRL (Crown Rump Length)mm	NT (Nuchal Translucency)mm
For 2nd Trimester;			
BPD (Biparietal Diameter)mm	Corrected gestational age (BPD)week.....day

Note of Physician to the Laboratory:

Requested by;
Physician Name/Surname:
Signature:
Telephone No:

Form filled/controlled by;
Name/Surname:
Signature:

Warnings:

For 1st Trimester Screening Test, CRL must be between 43.0-83.9 mm and corrected gestational age (CRL) must be between 11 weeks-13 weeks 6 days.

For 1st Trimester Screening Test, blood sampling and USG must be at the same day.

For 2nd Trimester Screening Test (Triple/Quadruple), gestational age must be between 15-21 weeks (Inclusive of 15th and 21st weeks) and BPD must be between 29.7-52.0 mm.

In multiple pregnancies, USG data should be mentioned for each fetus.

The risk for twin pregnancy has been calculated for a singleton pregnancy with corrected MoMs.

It is recommended that the obstetricians should be certified for NT and nasal bone measurements.