Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

First Trimester/Sequential Maternal Screening Patient Information

Patient Information

Name *(Last, First, Middle)*		Birth Date *(mm-dd-yyyy)*
Ordering Provider Name *(Last, First)*	Phone (required – include international/area code)	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

Clinical Information

1. Serum collection date *(mm-dd-yyyy)*: _____
2. Weight: _____ lbs or _____ kg

Ultrasound Information

3. Sonographer name *(Last, First)*: _____
4. Sonographer code (Mayo-assigned): _____
5. Ultrasound date *(mm-dd-yyyy)*: _____
6. CRL-A (Crown Rump Length): _____ mm
7. NT-A (Nuchal Translucency): _____ mm
8. If twins, A. CRL Twin: _____ mm B. NT Twin: _____ mm

Clinical History

9. Number of fetuses: ☐ 1 ☐ 2 **Note:** Risk estimate not available for 3 or more fetuses.
   If twins, number of chorions: ☐ Monochorionic ☐ Dichorionic ☐ Unknown
10. Insulin dependent diabetic: ☐ Yes ☐ No Select Yes if the patient is on insulin prior to this pregnancy; otherwise, select No.
11. Race: ☐ Black ☐ Non-black/Other
12. In-vitro fertilization: ☐ Yes ☐ No The age of the egg affects the risk calculations.
    If egg donor (other than patient), provide donor birth date *(mm-dd-yyyy)*: _____ or current age: _____
    If frozen egg or embryo is used, provide egg or embryo freeze date *(mm-dd-yyyy)*: _____
13. Has the patient had a previous pregnancy with Down syndrome (trisomy 21) or other trisomy? ☐ Yes ☐ No
14. Has the patient had a previous pregnancy with Neural Tube Defects (NTD)? ☐ Yes ☐ No
15. Does the patient or the father of the baby have a NTD? ☐ Yes ☐ No
16. Is this a repeat serum screen? ☐ Yes ☐ No If Yes and is a MayoAcess client, indicate "repeat screen" in performing lab notes.
17. Current cigarette smoking status: ☐ Non-smoker ☐ Smoker
18. Sonographer reviewer ID: _____

General Risk Assessment Information

First trimester Down syndrome and trisomy 18 risk assessments are available from 10 weeks, 0 days to 13 weeks, 6 days, which corresponds to CRL measurements between 31 and 80 mm.

Information Required

- By providing all information listed above, the most accurate patient-specific risk can be calculated.
- An uninterpretable report will be generated when the following are not provided: Serum collection date, birth date, weight, and ultrasound information.

If you have questions, call 800-533-1710 and ask for the Maternal Screening area.

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