



PRENATAL SCREENING REQUEST FORM

First Trimester (Dual Marker 9.0-13.6 wks) Triple and Quad Marker (14.0-22.6 wks)

Patient Name MRS. Himani Singh Sample collection date : _____

Vial ID : _____

Date of Birth (Day/Month/Year) : 1/3/1994

Weight (Kg) : 58/Kg

L.M.P. (Day/Month/Year) : 29/10/2022

Gestational age by ultrasound (Weeks/days) : _____ Date of Ultrasound : 1/1/

Nochal Translucency(NT) (in mm) : _____ CRL (in mm) : _____ BPD : _____

Nasal bone (Present/Absent) _____

Ultrasound report : First trimester Second trimester

Sonographer Name : _____

Diabetic status : Yes No

Smoking : Yes No

No. of Fetuses : Single Twins

Race : Asian African Caucasian Others

IVF : Yes No If Yes, Own Eggs Donor Eggs

If Donor Eggs, Egg Donor birth date : 1/1/

Previous pregnancies :

With Down Syndrome : Yes No

With Neural tube Anomaly : Yes No

Any other Chromosome anomaly : Yes No

Signature : हिमंशु सिंह

