SPLCG031

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PRENATAL SCREENING REQUEST FORM

TSH - AIPT

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

Patient Name : Smt Harshagree **Sample collection date :**

Vial ID : 24245182

Date of Birth (Day/Month/Year) : 6/3/1990

Weight (Kg) : 65 kg.

L.M.P. (Day/Month/Year) : 08/03/2023

Gestational age by ultrasound (Weeks/days) :____ **Date of Ultrasound :**__/__/__

Nuchal Translucency(NT) (in mm):_____CRL (in mm) :____BPD : _____

Nasal bone (Present/Absent)

Ultrasound report : First trimester O Second trimester O

Sonographer Name : [illegible]

Diabetic status : Yes O No O

Smoking : Yes O No O

No.of Fetuses : Single O Twins O

Race : Asian O African O Caucasian ☐Others O

IVF : Yes O No O **If Yes,** Own Eggs O Donor Eggs O

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

Previous pregnancies :

With Down Syndrome : Yes O No O

With Neural tube Anomaly : Yes O No O

Any other Chromosome anomaly : Yes O No O

Signature : Harsha 9685883803