NABL MC-3693

TEST REQUISITION FORM (TRF)

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SPL CODE : SPLCG1020 MSP Pathaldb **Date :** 17/09/24

S.No.	Patient Name in Capital	Age/Sex	Test Code & Test Name	Sample Type	Barcode No.	Sample Collection Date & Time	Ref. Customer	Referral Doctor
1.	Mrs. SONALI	30/F	Dual Markers	~~SERUM~~	A0660069			Dr. Dubey MD
2.			[TSH, HPLC]	~~EDTA~~	A0660067			
3.			HIGHT - 5.0					
4.			~~WEIGHT~~ - 71					
5.			LMP - 29/06/24					
			DOBO - 04/09/1992					
			MOVO - 9788[illegible]78					

* Note Attached Clinical Report If Required

Vitals
Fetal Medicine & Diagnostics
For Appointment Call : 91 87522 79404

Dr. Mamta Patel Jaiswal
Reg. No. CGMC 2640/2010
MBBS, DMRD (Gold Medalist)
Fellowship Fetal Med (Ahmedabad)
Former Consultant Rio Clinic

Patient name	Mrs. SONALI	**Age/Sex**	30 Years / Female
Patient ID	E15845-24-08-13-22	**Visit no**	1
Referred by	Dr. JYOTSANA	**Visit date**	13/08/2024
LMP date	29/06/2024, LMP EDD: 05/04/2025[6W 3D]		

OB - Early pregnancy Scan Report

Real time B-mode ultrasonography of gravid uterus done.

Route: Transvaginal

Intrauterine gestation

Fetus

Survey

Gestational sac	: Gestational Sac seen. Sac margins appeared regular
Yolk sac	: Yolk sac seen
Fetal activity	: Embryo seen
Cardiac activity	: Cardiac activity present Fetal heart rate - 123 bpm

Biometry(Haltmann,Kobayashi,Hadlock, Unit: mm)

GSac	16, 5W 6D	
CRL	5.9, 6W 2D	(46%)

Impression

Intrauterine gestation corresponding to a gestational age of 6 Weeks 3 Days

Gestational age assigned as per LMP

USG averaged Gestational age 6 weeks 3 days; EDD-05/04/2025

Disclaimer

Declaration :- Myself, DR. MAMTA PATEL JAISWAL declare that while conducting ultrasonography on this patient, I have neither detected nor disclosed the sex of her foetus to any body in any manner.

DR. MAMTA PATEL JAISWAL
DMRD, Fellow fetal medicine
Consultant Radiologist & Sonologist

Note: Investigations have their limitations, Solitary Pathological/Radiological and other investigations never confirm the final diagnosis of disease. They only help in diagnosing the disease in correlation to clinical symptoms & other related tests. Please Interpret accordingly.

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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. Somali **Sample collection date :**

Vial ID : A0660069

Date of Birth (Day/Month/Year) : 04/09/1992

Weight (Kg) : 71

L.M.P. (Day/Month/Year) : 29/06/24

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 ○ 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 :__/__/__

Previous pregnancies :

With Down Syndrome : Yes ○ No ⊖

With Neural tube Anomaly : Yes ○ No ⊖

Any other Chromosome anomaly : Yes ○ No ⊖

Signature :