Geisinger

Laboratory Medicine

1-800-695-6491

INFORMATION FORM – QUAD SCREEN MATERNAL SERUM SCREEN

PLEASE SUBMIT THIS FORM WITH REQUEST FOR QDSCRN

GML CLIENT CODE: _____

PHYSICIAN NAME:_____

MEDICAL RECORD NUMBER: _____

PATIENT NAME: (LAST)_____(FIRST)_____(MI)____

PATIENT'S DATE OF BIRTH: (MONTH/DAY/YEAR) _____

DATE OF SAMPLE COLLECTION: (MONTH/DAY/YEAR) _____

PATIENT'S WEIGHT: (On date of sample collection.)_____POUNDS

PATIENT'S RACE: [ ] White [ ] Black [ ] Other_____

ESTIMATED DATE OF DELIVERY (EDD):_____

EDD DETERMINED BY: LMP OR ULTRASOUND

NUMBER OF FETUSES: (1) (2) (3) (OTHER)

WAS MOTHER AN INSULIN-DEPENDENT DIABETIC PRIOR TO PREGNANCY? [ ] YES [ ] NO

IS THIS A REPEAT SPECIMEN? [Yes] [No]

DID MOTHER HAVE PREVIOUS FETUS/CHILD WITH NEURAL TUBE DEFECTS? [ ] YES [ ] NO

BRIEF HISTORY NTD_____

DID MOTHER HAVE PREVIOUS FETUS/CHILD WITH DOWN'S SYNDROME? [ ] YES [ ] NO

IS THIS A DONOR EGG? [ ] YES [ ] NO

DONOR AGE AT EGG RETRIEVAL:_____

DOES THE PATIENT CURRENTLY SMOKE CIGARETTES? [ ] YES [ ] NO