NorthShore
University HealthSystem

Laboratory Services
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MATERNAL SERUM SCREENING

CLINICAL IMMUNOLOGY LAB ***(847) 570-2741 (PHONE) (847) 733-5116 (FAX)***

Physician:_____

Address:_____ Telephone:_____

Please provide all information so that we can calculate MOM and provide risk interpretation

TEST REQUESTED (*check ONE only):*

☐ **AFP-Maternal Serum (Test # 4944)** **Date Of Sample Draw:** _____
(*ONTD only – does not include Down Syndrome Screen)*

☐ **AFP Quad Screen (Test # 2003)**
(Total B-hCG, AFP, Unconjugated Estriol, Dimeric Inhibin A)

PATIENT INFORMATION

Name: _____

Maternal Birth Date: ___ /___ /_____

DATA FOR CORRECTION FACTORS

Weight: _____ (lb) Race: W B O Insulin Dependent Diabetic: Y N

No of fetuses: _____

Is this the first MSAFP screening test for this pregnancy? Y N
If no, what is date of previous test? _____

Is there a donor egg mother who is different from the birth mother? ☐ Yes ☐ No

If yes, what is donor egg mother's AGE? Years:

GA by: *(circle ONE)*	***Ultrasound***	***LMP***	***Physical Exam***	***EDC/EDD***
Date:	*		**	
GA (Weeks-days)				

Notes:

- *Please complete information for **ONE GA** choice only.*

* *For US (Ultrasound) provide date of ultrasound & GA on that date. (Computer will automatically compute GA to draw date on final report.)*

** *For PE (Physical Exam) provide date of physical exam and GA on that date. (Computer will automatically compute GA to draw date on final report.)*

- ***This laboratory has normal ranges for 15 weeks through 21 weeks 6 days GA.***

GA = Gestational Age
LMP = Last Menstrual Period
EDC/EDD = Estimated Date of Confinement/Estimated Date of Delivery