

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)**
(ONTD only – does not include Down Syndrome Screen)

Date Of Sample Draw: _____

☐ **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