

Referring Doctor		Doctor's Code		Doctor's NMA No.		URGENT <input type="checkbox"/>					
Hospital & Ward				File Number		Contact Person:					
Patient Surname			Patient First Name			Please tick no. supplied (✓) Tel <input type="checkbox"/> Fax <input type="checkbox"/> Cell <input type="checkbox"/>					
Address / Postal Address											
Tel. (h)			Tel. (w)			Cell			E-mail		
Date of Birth	D	M	Y	GENDER (✓)		M		F		Company / Health Insurance	
Company I.D No. Health Insurance No.											
BILL PATIENT				BILL HOSPITAL				BILL COMPANY / HEALTH INSURANCE			

Relevant Clinical Data and Present Medication: LMP FASTING (✓) YES NO

Other Tests:

DOWN'S SYNDROME and OPEN NEURAL TUBE SCREENING

General patient information. Must be completed in all cases:

PATIENT'S DATE OF BIRTH: d d m m y y y y

ETHNIC ORIGIN (✓) white coloured black asian

WEIGHT (at time blood taken): . kg

NUMBER OF FOETUSSES:

DATE BLOOD SPECIMEN TAKEN: d d m m y y y y

Please indicate (✓) which screen is required and complete that section only:

1236 2nd TRIMESTER

Take blood from 15w to 20w 6d

Please complete:

1094 AFP only (NTD)

Take blood/fluid from 15w to 20w 6d

IS THE PATIENT A TYPE 1 DIABETIC (IDDM)? (✓) No Yes

GESTATIONAL AGE according to sonar: weeks days

ON d d m m y y y y

(Date when sonar was taken)

LMP (if sonar not done): d d m m y y y y

1237 1st TRIMESTER

Take blood from 11w to 13w 6d

Keep blood specimen cool, centrifuge within 6 hours. Send serum on ice.

Please complete:

PREVIOUS CHROMOSOMAL ANOMALY (✓): No T21 T18 T13

DOES THE PATIENT SMOKE ? (✓) No Yes

DATE ON WHICH SONAR WAS DONE: d d m m y y y y

CROWN-RUMP LENGTH on above date: . mm

NUCHAL TRANSLUCENCY (NT) . mm

SONAR PERFORMED BY:

**The reliability of risk determination depends on the accuracy of the above data.
 Please write clearly to prevent transcription errors.**

530 Home		FOR LABORATORY USE					
Collected by		Date		Received by		Logged by	
Location code		Time		Date		Time	
						<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40	