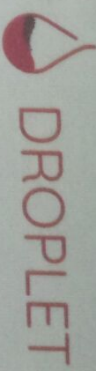


# MSS FORM / TEST REQUISITION FORM

## DOUBLE / TRIPLE / QUADRUPLE MARKER PRENATAL SCREENING TEST

36929



FOR RISK ASSESSMENT OF PATIENT FOR FETAL DOWN SYNDROME (TRISOMY 21) / NEURAL TUBE DEFECT (ONTDS) / EDWARD SYNDROME (TRISOMY 18)

TEST REQUESTED:  DOUBLE MARKER  TRIPLE MARKER  QUADRUPLE MARKER

<b>PERSONAL DETAIL:</b>	<b>MATERNAL RACE:</b>	<b>SAMPLE TYPE:</b>
PATIENT WEIGHT (Kgs) <u>6</u>	ASIAN <input checked="" type="checkbox"/>	INITIAL SCREENING: <input checked="" type="checkbox"/>
DOB: <u>04 / 04 / 1995</u>	CAUCASIAN	REPEAT SAMPLE: _____
LMP: <u>21 / 04 / 2020</u>	AFRICAN	DATE OF LAST COLLECTION: _____
DRUG HISTORY:	OTHER	DATE OF LAST REPORTING: _____

<b>MATERNAL HISTORY:</b>	<b>ULTRASOUND DETAILS:</b>
SMOKING: YES / NO <input checked="" type="checkbox"/>	*PHOTO / COPY OF RECENT ULTRASOUND: MANDATORY
PAST H/O DOWN SYNDROME YES / NO <input checked="" type="checkbox"/>	DATE OF ULTRA SOUND: <u>18 / 07 / 2020</u>
PAST H/O NEURAL TUBE DEFECT YES / NO <input checked="" type="checkbox"/>	CRL MEASUREMENT (mm): <u>56 mm</u>
INSULIN DEPENDENT DIABETES YES / NO <input checked="" type="checkbox"/>	NUCHAL TRANSLUCENCY THICKNESS (mm): _____
BLEEDING/SPOT IN LAST 2 WEEKS YES / NO <input checked="" type="checkbox"/>	BPD MEASUREMENT (mm): <u>17 mm</u>
IVF PREGNANCY YES / NO <input checked="" type="checkbox"/>	AVERAGE GESTATIONAL AGE ON THE DAY OF USG: <u>13 WEEKS</u>
PREVIOUS PREGNANCIES _____ LIVE <input checked="" type="checkbox"/>	NAME OF SONOLOGIST: <u>DR. KAMA MANIYELA</u>

\* PHOTO / PHOTOCOPY OF RECENT ULTRASOUND IS MANDATORY WITH THIS FORM

PATIENT NAME: UPASANA SIGNATURE OF PATIENT: