

AFP TESTING PATIENT INFORMATION

Date: ____ / ____ / ____

- Patient Last Name: _____ Patient First Name: _____
- Date of Birth: ____ / ____ / ____
- Weight: _____ lbs.
- Race: Asian Black Caucasian Hispanic Native American Oriental
- Gestational Age: weeks ____ days ____, as of the following date: ____ / ____ / ____
Determined by: LMP Ultrasound
- Date of Last Menstrual Period (LMP): ____ / ____ / ____
- Due Date (EDD): ____ / ____ / ____ Determined by: LMP weeks ____ days ____ Ultrasound
- Does the patient have Insulin Dependent Diabetes: Yes No
- Is this Pregnancy: Singleton Twins Triplets
- Is this IVF Pregnancy? Yes No If yes, donor's date of birth ____ / ____ / ____
- Is this a repeat of a previous abnormal specimen in this pregnancy? Yes No
- Is there a Neural Tube Defect family history? Yes No Unknown
If yes, what was the defect and the relation (ex. Self, Sibling, Offspring)?
- Is there a Down Syndrome family history? Yes No Unknown
- Does the Patient have a smoking history? Yes No

A maternal serum interpretation cannot be determined on patients with a gestational age of less than 15 weeks, 0 days or more than 20 weeks, 6 days.