

Prenatal Screening Data Pad



Patient Name: _____

Patient DOB: _____

Physician: _____

Clinic: _____

1. Specimen Collection Date: ____ / ____ / ____

2. Ethnicity:

- African American Asian Hispanic
 Caucasian Other: _____

3. LMP Date: ____/____/____ OR U/S date ____/____/____ and

EDD date: ____/____/____ by U/S LMP

4. # of Fetuses: 1 2 >2: Specify #: _____

5. Maternal Weight: _____ lbs

6. Insulin-Dependent Diabetic prior to pregnancy? Yes No

Previous Down Syndrome pregnancy/child? Yes No

Family history of NTD? Yes No

If Yes, specify: _____ Relative _____

Is patient on anti-convulsants? Yes No

If Yes, specify: _____

7. Other: _____

November 2007