

# Genetics Information Form

Maternal Serum QUAD Screen - AFP Amniotic Fluid – AFP Serum  
Chromosome Studies - Products of Conception - Cystic Fibrosis

Lab Use Only Last Name \_\_\_\_\_ First Name \_\_\_\_\_

MDOB COLEC Date of Birth \_\_\_\_\_ Specimen Collection Date: \_\_\_\_\_

DOCNM DOCPH Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

RACEI Race/Ethnic group (please circle one):

*Caucasian Native American Ashkenazi Jew Hispanic Black Asian*

## Complete for Maternal Serum QUAD and AFP Amniotic Fluid or Serum

IVFPR IVFDD • Conception by IVF? [ ] yes [ ] no Ovum Donor Date of Birth \_\_\_/\_\_\_/\_\_\_

IVFZ *If frozen egg or embryo used, how long frozen? \_\_\_\_\_years \_\_\_\_\_months*

MOTWT • Mother's Current weight: \_\_\_\_\_pounds

TWINS • Twin pregnancy? (Must have an Ultrasound Estimated Date of Delivery for twins) Yes No

DIAHX • Insulin dependent diabetic prior to pregnancy? (circle one) Yes No

DOWHX • Pregnancy with Down Syndrome or other Trisomy? (circle one) Yes No

RPTTS • Is this a repeat specimen? (circle one) Yes No

EDDI • Estimated Date of Delivery \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

EDDTY • Estimated Date of Delivery determined by (check one below)

[ ] Ultrasound [ ] Last Menstrual Period

*\*If neither ultrasound or LMP was used to determine estimated date of delivery, then provide the date of the exam and weeks gestation on the date of the exam. (see below)*

EXDAT *Physical exam date: \_\_\_\_\_*

EXGES *Baby's age on physical exam date \_\_\_\_\_weeks\_\_\_\_\_days*

## Complete this section for Chromosome Studies, POC, Cystic Fibrosis

• Is patient currently pregnant? Yes No

• Reason for testing: [ ] Screening [ ] Carrier testing Other \_\_\_\_\_

• Family History? Yes No

• Has patient or family member had test before? Yes No

*If yes, explain: \_\_\_\_\_*

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