

## Second Trimester Maternal Screening Alpha-Fetoprotein (AFP)/Quad Screen Patient Information

### Patient Information

Patient Name <i>(Last, First, Middle)</i> _____		
Ordering Physician Name <i>(Last, First)</i> _____	Phone _____	Fax* _____

\*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

### Clinical Information

1. Serum Collection Date <i>(mm-dd-yyyy)</i> _____
2. Birth Date <i>(mm-dd-yyyy)</i> _____
3. Estimated Date of Delivery <i>(mm-dd-yyyy)</i> _____ by <input type="checkbox"/> Ultrasound <input type="checkbox"/> Last menstrual period
Note: Dating method impacts risk calculation and screening performance. Ultrasound dating increases overall screening performance and is required for twin gestations.
4. Weight _____ lbs or _____ kg

### Clinical History

5. Medication-dependent diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No      Select Yes if patient has a history of medication-dependent diabetes mellitus at the time of conception (oral or insulin).
6. Patient race <input type="checkbox"/> Black <input type="checkbox"/> Other/Non-black/Mixed
7. Number of fetuses <input type="checkbox"/> 1 <input type="checkbox"/> 2      Risk estimate not available for 3 or more fetuses. If twins, number of chorions <input type="checkbox"/> Monochorionic <input type="checkbox"/> Dichorionic <input type="checkbox"/> Unknown
8. In-vitro fertilization <input type="checkbox"/> Yes <input type="checkbox"/> No      The age of the egg affects the risk calculations. If egg donor (other than patient), provide donor birth date <i>(mm-dd-yyyy)</i> _____ or current age _____ If frozen egg or embryo used, how long was egg or embryo frozen <i>(years, months)</i> _____
9. Has the patient had a previous pregnancy with Down syndrome (trisomy 21) or other trisomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has the patient had a previous pregnancy with neural tube defects? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the patient or father of the baby have a neural tube defect? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is this a repeat serum screen? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes and MayoAccess client, indicate "Repeat screen" in performing lab notes.
13. Current cigarette smoking status <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker

### General Risk Assessment Information

<ul style="list-style-type: none"> <li>Neural tube defect risk assessment is available from 15 weeks and 0 days to 22 weeks and 6 days; 16–18 is preferred.</li> <li>Down syndrome and trisomy 18 risk assessment is available from 14 weeks and 0 days to 22 weeks and 6 days.</li> </ul>
<b>Information Required</b> <ul style="list-style-type: none"> <li>By providing all information listed above, the most accurate patient-specific risk can be calculated.</li> <li>An uninterpretable report will be generated when the following are not provided: serum collection date, birth date, estimated date of delivery, and weight.</li> </ul>

If you have questions, contact Mayo Medical Laboratories at 800-533-1710 and ask for the Maternal Screening area.