Saint Luke's Regional Laboratories
Client Services Department
4401 Wornall Rd
Kansas City, MO 64111
(816) 932-3850

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Maternal Serum Screening Requisition

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	**DATE OF BIRTH**
ORDERING PROVIDER NAME	PROVIDER PHONE NUMBER

FORM TO BE SUBMITTED WHEN ORDERING:

☐ AFP MATERNAL SERUM (AFP NTD)

☐ AFP QUAD/TETRA (AFP, HCG, Dimeric Inhibin A, Unconjugated Estriol)

1. Serum collection Date ____
2. Gestational age on date specimen was drawn: _________________Weeks
3. EDD ______________________________BY ☐ ULTRASOUND ☐ LMP ☐ EDC
4. Multiple Birth: ☐ Twins ☐ Triplets ☐ Other
5. Weight_____________________lbs or _______________________kg
6. Patient's Race: ☐ Caucasian ☐ African American ☐ Other ☐ Asian ☐ American Indian
7. Diabetic Status: ☐ Insulin Dependent ☐ Non - Diabetic

PATIENT HISTORY - CHECK ALL THAT APPLY

☐ Prior Neural Tube Defects (NTD)

☐ Down Syndrome(Trisomy 21) or other trisomy

☐ Ultrasound Anomalies

☐ Previous AFP Specimen during this pregnancy

☐ Other – please explain____

GENERAL RISK ASSESSMENT INFORMATION

- **Neural tube defect (NTD) risk assessment is available from 15 weeks, 0 days to 23 weeks, 6 days (16 – 18 weeks is preferred for NTD assessment)**
- **Down syndrome and trisomy 18 risk assessment is available from 15 weeks, 0 days to 21 weeks, 6 days**

For Laboratory Use Only:

SPECIMEN # ____