Prenatal Screening Data Pad

Allina Health LABORATORY

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: _____