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

Last Name_____ First Name_____

Date of Birth_____ Specimen Collection Date:_____

Physician Name_____

Compete for Maternal Serum QUAD and AFP Amniotic Fluid or Serum

Estimated Date of Delivery_____/_____/_____

Method Used to Determine EDD (circle one) Ultrasound LMP (Last Menstrual Period)

Mother's Current weight _____pounds

Insulin dependent diabetes? (circle one) Diabetic None

Race: Black _____Non-Black_____

Number of Fetuses? (circle one) 1 2 3 or more

Number of Chorions? (circle one if applies) Monochorionic Dichorionic Unknown N/A

IVF Pregnancy? (circle one) No Yes

IVF Egg Donor Date of Birth (if not patient) _____/_____/_____
IVF Egg or Embyro Freeze Date _____/_____/_____

Previous Pregnancy with Down (T21)/Trisomy? Yes No Unknown

Previous Pregnancy with Neural Tube Defect? Yes No Unknown

Patient or father of baby has a NTD? Yes No Unknown

Physician Phone Number_____

Complete for Chromosome Studies, POC, Cystic Fibrosis

Race/Ethnic Group: (please circle one)
Caucasian Native American Ashkenazi Jew Hispanic Black Asian

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

Explain_____