ALVERNO LABORATORIES

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PRENATAL RISK ASSESSMENT FORM

The following information **must** be obtained from the **physician's office**.

Patient Name_____ **Date of Birth**_____

Physician_____ **Specimen Collection Date**_____

Patient's weight _____**lbs** OR _____**kgs** **Physician Phone**_____

Due date (EDC)_____**Determined by:**

____ last menstral period, confirmed by ultrasound
____ last menstral period. Date:_____
____ ultrasound

Number of fetuses?

_____Singleton _____Twins _____Unknown

For twins, is pregnancy monochorionic? ____No _____Yes ____ Unknown

Patient's race?

_____Non-Black _____Black _____Unknown

Was the patient diabetic at the time of conception?

_____No _____Yes

Does the patient currently smoke cigarettes?

_____No _____Yes

Has the patient taken valproic acid or carbamazepine during this pregnancy?

_____No _____Yes; specify medication:_____

Has the patient had a previous pregnancy with trisomy? (i.e., Down syndrome, trisomy 18 or 13)

_____No _____Yes; specify abnormality:_____

Is there a family history of neural tube defects? (i.e., spina bifida, anencephaly, encephalocele)

_____No _____Yes; specify the relationship of the affected individual to the fetus:_____

Is this an in vitro fertilization preganancy?

_____No _____Yes; specify the age of the egg donor, if used:_____years

Has the patient had a previous maternal serum screen in this pregnancy?

_____No _____Yes _____Uknown