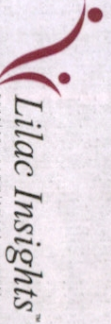


Sample Collection date: 17042023 Sample Collection time: _____ am/pm
 Sample Collection from: _____ Sample Collected By: _____

Requisition form for Prenatal Screening

Bill on week 17

Office No-301 & 302, Rupa Solutaire Premises C.S. Ltd.
 Sector-1, Building No-A-1, Millennium Business Park,
 MIDC Mahape, New Mumbai-400710
 T: +91 22 4184 1438 F: +91 22 4184 1448



Patient Details:
 Name: Mamisha
 Address: Brelbarga
 City: Brelbarga State: Karnataka
 Pincode: _____
 City: Brelbarga State: Karnataka
 Hosp. ID: _____
 DOB: 05022000 Weight: 62 kg Height: 159 cm
 Ethnicity: South Asian East Asian Caucasian African Other Smoking status

Ultrasound History

First trimester ultrasound details
 USG date: 17042023
 CRL: 7.00 mm NT: 0.3 mm
 NB: Present Absent

Twin pregnancy ultrasound details

USG date: DDMMYY

DCDA MCDA MCMA

	Twin A	Twin B
CRL	_____ mm	_____ mm
NT	_____ mm	_____ mm
NB	<input type="checkbox"/>	<input type="checkbox"/>
	Present Absent	Present Absent

Second trimester ultrasound details

USG date: DDMMYY

BPD _____ mm
 FL _____ mm
 HC _____ mm

Requesters Information:

Name of Hospital/Collection Centre: Bendale Hospital
 City: Brelbarga
 Name of Ordering Physician: Dr Madhura Banale
 Name of Sonographer: Dr Madhura Banale
 FMF code (if available): _____

Pregnancy Details:

LMP: 10012023 USG/Corr EDD: 22102023
 LMP certainty: Regular Irregular Unknown

Obstetric History:

Parity (pregnancy at ≥24 weeks): 01 Gravida: 02 Abortion: 0 Live: 01
 Details of last pregnancy at ≥ 24 weeks
 PE: Yes No Date of delivery: 20092020
 GA at delivery: _____ Weeks _____ Days

Present pregnancy: Singleton Twin Vanishing Twin

Type of Conception: Natural Assisted Ovulation drugs

If assisted reproduction, kindly mention the type of procedure _____

Extraction date: _____ Transfer date: _____

Egg source: Self/ donor. If donor, then donor's age/DOB: _____

Diabetes: Yes If Yes, Type: Gestational Type 1 Type 2

Treatment method: No treatment / Insulin / Metformin / Insulin+Metformin / Diet Control

If on Insulin, Insulin start date: _____

Patient on hCG: Yes If yes, latest date of hCG intake: _____

Bleeding/Spotting in last two weeks: Yes

Previous pregnancy History:

History of Down Syndrome: Yes No Edwards' Syndrome: Yes No Patau Syndrome: Yes No ONTD: Yes No

History of Systemic Lupus Erythematosus: Yes No History of Anti Phospholipid Syndrome (APLA): Yes No

First trimester Screening (FTS) (10 weeks to 13.6 weeks)

1. Combined First Trimester Screening
2. First Trimester Screening + Pre-eclampsia (without PIGF)
3. First Trimester Screening + Pre-eclampsia (with PIGF)
4. Early Biochemistry
5. Only Biochemistry values
6. Biochemistry Only
7. First Trimester Enhanced
8. First Trimester Enhanced + Pre-eclampsia (with PIGF)

Second trimester Screening (STS) (15 weeks to 21.6 weeks) STS cannot be performed in twin pregnancy

9. Triple marker test
 10. Quadruple marker test
 11. Quadruple- Integrated Screening
1. NT + Free β-hCG + PAPP-A
 2. NT + Free β-hCG + PAPP-A + MAP + UAD
 3. NT + Free β-hCG + PAPP-A + PIGF + MAP + UAD
 4. Free β-hCG + PAPP-A
 5. Free β-hCG + PAPP-A
 6. Free β-hCG + PAPP-A
 7. Free β-hCG + PAPP-A + AFP + PIGF
 8. Free β-hCG + PAPP-A + AFP + PIGF + MAP + UAD
 9. Free β-hCG + AFP + uE3
 10. Free β-hCG + AFP + uE3 + Inhibin A
 11. NT + PAPP-A + Free β-hCG + AFP + uE3 + Inhibin A

Pre-eclampsia Screening (PIGF + PAPP-A + MAP + UAD)

Pre-eclampsia and Fetal Growth Restriction:

Blood pressure (BP) history BP measurement date: DDMMYY

Markers	Left arm		Right arm		MAP
	Systolic BP	Diastolic BP	Systolic BP	Diastolic BP	
Blood pressure (mm/Hg)					
First reading			<u>120</u>	<u>80</u>	
Second reading					

The difference should not be more than 10 mmHg in first and second reading

Family History of Pre-eclampsia: Not Known No Patient Mother
 Chronic Hypertension: Not known No Medication Untreated
 Uterine Artery pulsative index (UAD-PI): Right PI _____ Left PI _____ (ua doppler acceptable range: 0.4 – 4)
 Previous small baby: Yes No

Thalassemia Screening Thalassemia (HPLC) Iron Therapy - Yes/No (Kindly send CBC/DOC, Blood transfusion History)

Important: 1) This form has to be completely filled up for us to process the sample. 2) Sample(s) accepted are subject to verification at our Laboratory. If sample found unfit for processing, the healthcare professional will be notified. 3) Kindly attach relevant copy(s) of diagnostic report(s).

Signature of the Patient: _____ Signature of Ordering Physician: _____



For Lilac Insights
 PAPP-A:
 β-hCG:
 AFP:
 PIGF:
 uE3:
 Inhibin A:
 sFit-1: