

Requisition form for Prenatal Screening

Patient Details:
 Name: HENA CATHA JAIN 38/F
 Address: 2, Agadwara
 City: GURUGRAM State: ANDHRA PRADESH
 Contact Number: 9440350819
 Email address: 18051983@gmail.com
 DOB: 18051983 Weight: 55.2 kg Height: 156 cm
 Ethnicity: Asian Caucasian African Other Folic acid intake: Yes No
 Smoking: Yes No

Requesters Information:

Name of Hospital: SUNITHASCANDRAGANASTHIC
 Collection Centre: GURUGRAM
 City: GURUGRAM
 Name of Ordering Physician: K. SUNEETHA GAJU
 Contact number of Ordering Physician: 9246481939
 Name of Sonographer: H. SUPRIYHA GAJU
 FMF code (if available):

Pregnancy History:

LMP: 12062021 USG/Corr EDD: 19032022
 LMP certainty: Regular Irregular Unknown
 Parity: Gravida 3 Para 0 Abortion 0 Live 2
 Present pregnancy: Singleton Twin
 Previous pregnancy: History of Down syndrome Yes/No Yes No
 Previous pregnancy: History of Edwards' syndrome / Patau syndrome / ONTD Yes/No Yes No
 Diabetes status: Insulin dependent Please Specify Gestational
 Patient on HCG: Yes No
 Bleeding/Spotting in last two weeks: Yes No
 Type of Conception: Natural Assisted Ovulation drugs
 If assisted reproduction, kindly mention the type of procedure

Extraction date: DDMMYY Transfer date: DDMMYY
 Egg source: Self donor, If donor, then donor's age/DOB: DDMMYY

Patent Consent: I have read & understood Test Requisition Form for Prenatal screening & Pre-eclampsia. I consent that my sample shall be the sole exclusive property of LILAC INSIGHTS PVT LTD & I transfer all my sample rights to LILAC INSIGHTS for its research and/or commercial use.

Sample Collection date: 14092021
 Sample Collection time: 05:15 am/pm
 Sample Collection from: _____
 Sample Collected By: _____

Ultrasound History

First trimester ultrasound details
 USG date: DDMMYY
 USG date: 14092021
 CRL: 74.1 mm NT: 4 mm
 NB: Present Absent

Twin pregnancy ultrasound details
 USG date: DDMMYY
 USG date: DDMMYY

Second trimester ultrasound details
 USG date: DDMMYY
 USG date: DDMMYY

	Present	Absent
NB	<input type="checkbox"/>	<input type="checkbox"/>
NT	<input type="checkbox"/>	<input type="checkbox"/>
CRL	<input type="checkbox"/>	<input type="checkbox"/>
FL	<input type="checkbox"/>	<input type="checkbox"/>
HC	<input type="checkbox"/>	<input type="checkbox"/>

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

Early Biochemistry: (10-11 wks) with NT at 11-13.6 wks (Free β HCG / PAPP-A)

Biochemistry combined with NT + Free β HCG/PAPP-A

Biochemistry only (Free β HCG/PAPP-A)

First trimester Enhanced: (AFP + Free β HCG + PAPP-A + PLGF)

Pre-eclampsia* (PLGF + PAPP-A + MAP + UAD)

SFLT / PLGF

AFP only

Integrated Screening

Triple marker test (AFP+Free β HCG + Unconjugated Estriol)

Quadruple test: (AFP + Free β HCG + Unconjugated Estriol + Inhibin A)

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

Pre-eclampsia: Blood pressure (BP) history

Markers	Left arm		Right arm	
	Systolic BP	Diastolic BP	Systolic BP	Diastolic BP
Blood pressure (mm/Hg)				
First reading				
Second reading				

Family History of Pre-eclampsia: Not Known Patient Mother
 Chronic Hypertension: Not Known Medication Untreated
 Uterine Artery pulsative index (UAD-PI): Left PI: _____ Right PI: _____
 (a doppler acceptable range: 0.4 - 4)

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 report(s) of diagnostic report(s).
 Signature of the Patient: _____
 Signature of Ordering Physician: _____

BAR CODE STICKER



For Lilac Insights
 PAPP-A: _____
 β-HCG: _____
 AFP: _____
 PLGF: _____
 UE3: _____
 Inhibin A: _____

Lilac
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