

Sample Collection date: **20/11/2024** Sample Collection time: **11:30 am/pm**
 Sample Collection from: **.....** Sample Collected By: **.....**

Requisition form for Prenatal Screening

Patient Details:
 Name: **Sampada Nayam**
 Address: **.....**

City: **Bandra** State: **M.P.** Pin Code: **.....**
 Email ID: **9907396499** Hospital ID: **.....**
 DOB: **25/6/1992** Weight: **65** kg Height: **5.3** cm
 Ethnicity: South Asian East Asian Caucasian African Other Smoking status: Yes No

Requesters Information:

Name of Hospital/Collection Centre: **Dr. Smitha Singh Clinic**
 City: **Indore**
 Name of Ordering Physician: **Dr. Smitha Singh**
 Name of Sonographer: **Dr. Riva Tapodi**
 FIMF code (if available): **.....**

Pregnancy Details:

LMP: **09/08/24** USG/Corr EDD: **.....**
 LMP certainty: Regular Irregular Unknown

Obstetric History:

Parity (pregnancy at ≥ 24 weeks): Gravida: **II** Abortion Live
 Details of last pregnancy at ≥ 24 weeks: **.....**
 PE: Yes No Date of delivery: **25/12/2023**
 GA at delivery: **40** 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 No 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 No If yes, latest date of hCG intake: **.....**
 Bleeding/Spotting in last two weeks: Yes No

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

Ultrasound History

First trimester ultrasound details
 USG date: **20-11-24**
 CR: **72.6** mm NT: **1.7** mm
 NB: Present Absent
 FHR: **149**

Twin pregnancy ultrasound details	
USG date	DCDA <input type="checkbox"/> MCDA <input type="checkbox"/> MCMA <input type="checkbox"/>
	Twin A Twin B
CRL	mm mm
NT	mm mm
NB	Present <input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/>

Important - USG report is mandatory to avoid discrepancies in the information through human error or missing out some important findings other than basic parameters required to perform the test.

TEST REQUESTED

- First Trimester Screening (FTS) (10 weeks to 13 weeks 6 days)**
- EVICO Duo : Dual Marker
 - EVICO Duo Plus : Dual Marker with Macrosonia
 - EVICO Duo PE : Dual Marker with Macrosonia & PE
 - EVICO Duo PE+ : Dual Marker with Macrosonia, SGAI/UGR & PE (with PLGF)
 - EVICO FT Enhanced PE : Enhanced FTS with SGAI/UGR, Macrosonia & PE
 - Only Biochemical Values

Note: The risk of pre-eclampsia (PE) and predispositions for macrosonia, SGAI/UGR cannot be obtained in twin and vanishing twin pregnancies.

- Second Trimester Screening (STS) (15 weeks to 21 weeks 6 days)**
 STS cannot be performed in twin pregnancy
- EVICO Quad : Quadruple Marker Test
 - EVICO Trio : Triple Marker Test
 - Integrated Screening
 - Pre-eclampsia Prognosis (After 20 weeks)
 - EVICO PE-Pro (sFlt-1/PlGF Ratio)

Fill this section for Pre-eclampsia screening:

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

The difference should not be more than 10 mm/Hg in first and second reading

Family History of Pre-eclampsia: Not Known Patient Mother
 Chronic Hypertension: Not known No Medication Untreated
 Uterine Artery pulsative index (UAD-PI): Right PI: **2.22** Left PI: **2.55** (via doppler acceptable range: 0.4 - 4)
 Previous small baby: Yes No

Thalassemia Screening

Hb-HPLC Test Iron Therapy: Yes No

Blood Transfusion History: Yes No

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: **.....**

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For Lilac Insights
 PAPP-A:
 β -hCG:
 AFP:
 PlGF:
 uE3:
 Inhibin A:
 sFlt-1: