Obstetrics Screening Laboratory

Department of Obstetrics and Gynaecology, The Chinese University of Hong Kong

Request Form – 1st Trimester Combined Down Syndrome & Pre-eclampsia Screening

Patient Information

Fill in or place the patient's label

Name: _____

HKID / Passport no.: _____

Pregnancy / Case no.: _____

Hospital / Centre: _____

Maternal Details

Actual DOB: D:___M:___Y: _____

Body Weight: _____kg

Height : _____cm

Gravida: _____ Parity: _____

Ethnicity

☐ **East Asian**
Chinese/Japanese/Korean/
Others: _____

☐ **Caucasian**
Caucasian/
Middle Eastern/
Others: _____

☐ **South East Asian**
Filipino/Indonesian/Thai/
Malay/Vietnamese/
Cambodian/
Others: _____

☐ **South Asian**
Pakistani/Bangladeshi/
Indian/Nepalese/
Others: _____

☐ **African/Caribbean**
Others: _____

Medical History **circle as appropriate*

Chronic HT: Y / N
SLE: Y / N
APS: Y / N
DM: Y / N
DM Type: 1 / 2
DM on insulin Y / N
Any prev. pre-eclampsia: Y / N
Family Hx of PET: Y / N
Smoking at conception Y / N

Current Pregnancy

EDC: D: ____ M: ____ Y: _____

Prev. aneuploidy: No / T21 / T18 / T13/
Others: _____

Conception: Natural / OI ± IUI / IVF / IVF + ICSI

IVF Details

Embryo number: Single / Multiple

Egg collection: D:___M:___Y: _____

Embryo transfer: D:___M:___Y: _____

Egg Donor DOB: D:___M:___Y: _____ or AGE:_____

Current Medication

Aspirin: Y / N Start date: D:_____ M: _____ Y: _____ Dosage: _____

The Most Recent Delivery Details

Date of Birth D: ____M: ___Y: _____Gestation:_____ wks _____days Birthweight: _____ kg

Blood Pressure

	LEFT Arm	RIGHT Arm
1st measurement	_____/_____	_____/_____
2nd measurement	_____/_____	_____/_____

Ultrasound Scan

Name of Sonographer: _____

Date of USG: D:_____M:_____Y:_____ Multiple pregnancy: DCDA / MCDA / MCMA /Other:_____

	Singleton / T1	T2	T3
CRL:	_____mm	_____mm	_____mm
NT:	_____mm	_____mm	_____mm
BPD:	_____mm	_____mm	_____mm
FHR:	_____bpm	_____bpm	_____bpm
Presentation: (For multiple pregnancies only)	L / R / Upper / Lower	L / R / Upper / Lower	L / R / Upper / Lower

Left Uterine Artery
PI: _____
PSV: _____

Right Uterine Artery
PI: _____
PSV: _____

Fetus USG findings: Exomphalos / Omphalocele: Y / N
Bladder ≥7mm / Megacystis: Y / N Others:_____

Maternal Blood Collection

Date: D:____M:____Y:_____ Time: hr____: min _____

Sample sent as : ☐ Clotted blood ☐ Serum

Requester's Information

Name : _____

Signature : _____

Centre & Tel: _____

IMPORTANT:

- Clotted blood samples should be sent within 24 hours of collection. It will NOT be processed if it arrives at laboratory more than 24 hours after collection.
- Samples should be kept at 2-8°C until shipment.
- Samples should be kept in an ice-box during transportation.
- Blood sample, CRL and NT should be taken between 11^0 to 13^6 weeks.
- Further information are available at http://www.obg.cuhk.edu.hk/
- For any enquiries, please call 3505 4217 or fax 2725 2638

Laboratory Use

FOR LABORATORY USE

Lab. No. :_____ Date & Time received : _____

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