

Request Form – 2nd Trimester Biochemical Down Syndrome 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

Chronic hypertension: ☐ No ☐ Yes

DM: ☐ No ☐ Yes

Previous preeclampsia: ☐ No ☐ Yes

Obstetrics History

LMP: D: ____ M: ____ Y: ____ EDC (by LMP / USG): D: ____ M: ____ Y: ____

Smoking during pregnancy: ☐ No ☐ Yes

Previous Aneuploidy: ☐ No ☐ T21 ☐ T18 ☐ T13

Mode of conception: ☐ Natural ☐ OI ± IUI ☐ IVF ☐ IVF + ICSI

IVF details:

Number of embryo transferred: ☐ Single ☐ Multiple ☐ Unknown Egg collection: D: ____ M: ____ Y: ____

Embryo transfer: D: ____ M: ____ Y: ____

☐ Egg Donor (please provide the DOB or age of Donor at Egg donation / freezing: D: ____ M: ____ Y: ____ or age ____)

Maternal Blood Collection

Date: D: ____ M: ____ Y: ____ Time: ____: ____

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.
- Further information are available at <http://www.obg.cuhk.edu.hk/>
- For any enquires, please call 3505 4217 or fax 2725 2638.

Laboratory
Use

FOR LABORATORY USE

Lab. No. : _____

Date & Time received : _____