MAYO CLINIC
Mayo Medical Laboratories

Second Trimester Maternal Screening Alpha-Fetoprotein (AFP)/Quad Screen Patient Information Sheet

Patient Name - Last Name	First Name	Middle Initial

Ordering Physician Name	Physician Phone *(with International and/or Area Code)*	MML Account Number *(if known)*

The following 10 questions MUST be completed in order to provide interpretation of test results.

1. **Serum Collection Date** _____
   (Month Day Year)
2. **Birth Date** _____
   (Month Day Year)
3. **Weight** _____ Lbs. or _____Kg.
4. **Insulin Dependent Diabetic?** ☐ Yes ☐ No *Select Yes if patient was on insulin prior to this pregnancy; otherwise select No*
5. **Race?** ☐ Black ☐ Other/Non-Black/Mixed
6. **Twin Pregnancy?** ☐ Yes ☐ No *Note: Ultrasound EDD is required for twin pregnancies. Risk estimates are not available for triplets or diabetic-twin pregnancies. If one twin is deceased, select No; however, analyte levels may be impacted.*
7. **In-Vitro Fertilization (IVF) ?** ☐ Yes ☐ No *The age of the egg affects the risk calculations.*
   If egg donor (other than patient), need donor DOB: _____ *or current age:* _____
   (Month Day Year)
   If frozen egg or embryo used, how long was egg or embryo frozen: _____
   Years Months
8. **Has this patient had a previous pregnancy with Down Syndrome (trisomy 21) or other trisomy?** ☐ Yes ☐ No
9. **Is this a repeat serum screen?** ☐ Yes ☐ No If yes, list previous control number: _____

10. **Gestational Information**
    - Neural tube defect (NTD) risk assessment is not available before 15 weeks, 0 days, by ultrasound; 16-18 weeks is preferred.
    - Risk assessment for Down syndrome and trisomy 18 is available from 14 weeks, 0 days to 22 weeks, 6 days.

    EDD _____ **by ☐ Ultrasound or ☐ LMP** *Note: Results will differ depending on method checked. Ultrasound dating increases overall screening performance and is required for twin gestations.*
    (Month Day Year)

    If LMP is unknown and ultrasound has not been performed, provide other dating, such as physical exam or IVF. Please be specific. For IVF, specify which day embryo transfer occurred (day 3-5) and date of transfer. For physical exam, provide exam date and weeks gestation on the *date of exam.*

Please note that we are unable to calculate risks for samples received without the necessary information.

If you have questions, contact Mayo Medical Laboratories at 1-800-533-1710 and ask for the Maternal Screening area.

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MML Supply T595
MC1235-123rev0408