Please complete, print and submit.

MAYO CLINIC
Mayo Medical Laboratories

First Trimester Maternal Screening PAPP-A, hCG, and NT Patient Information

Reset Form

The first 12 questions MUST be completed in order to provide interpretation of test results.
Complete Question 13 if it is a twin pregnancy.

Patient Name - Last Name	First Name	Middle Initial

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

1. **Serum Collection Date** _____
(Month Day Year)

2. **Date of Birth (DOB)** _____
(Month Day Year)

3. **Weight** _____ **lbs** *or* _____ **kg**

4. **Insulin Dependent Diabetic?** ☐ Yes ☐ No *Select Yes if patient on insulin prior to this pregnancy; otherwise, select No.*

5. **Race?** ☐ Black ☐ Other/Non-Black/Mixed

6. **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

7. **Has this patient had a previous pregnancy with Down Syndrome (trisomy 21) or other trisomy?** ☐ Yes ☐ No

Ultrasound Information

8. **Sonographer Name** _____

9. **Sonographer Code** *(Mayo Assigned)* _____

10. **Ultrasound Date** _____
(Month Day Year)

11. **CRL-A** *(Crown Rump Length)* _____ mm

12. **NT-A** *(Nuchal Translucency)* _____ mm

13. **If Twins** (NOTE: Risk estimates not available for 3 or more fetuses):

A. **CRL-B** _____ mm

B. **NT-B** _____ mm

C. ☐ Monochorionic ☐ Dichorionic ☐ Unknown

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 Maternal Screening Area.

Part 1 – Mayo Copy Part 2 – Client Copy
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