MAYO CLINIC
Mayo Medical Laboratories

LABORATORY SERVICE REPORT

1-800-533-1710

PATIENT NAME	PATIENT NUMBER	AGE	SEX	ACCESSION #
TEST409, 409	L3MRNG9161999	35	F	G9161999

ORDERING PHYSICIAN	CLIENT ORDER #	ACCOUNT #
		LIAISONS

COLLECTION DATE TIME	RECEIVED DATE TIME	REPORT PRINTED DATE TIME	SPECIMEN INFORMATION
12/20/10 12:01 P		03/09/11 07:29 A	DATE OF BIRTH:

Test Client
Attn: Mayo Liaisons
200 First Street SW
Rochester, MN 55905
507-284-8202

TEST REQUESTED	HI LO		REF RANGE	PERFORM SITE *
Sequential Maternal Screen, Part 1			**REPORTED: 12/22/10 10:10 A**	
Collection Date 1	**10-31-10**			**SDL**
Maternal Birthdate	**02-16-81**			**SDL**
Maternal Weight	**120**	**lbs**		**SDL**
Insulin Dependent Diabetes	**None**			**SDL**
Black Race	**No**			**SDL**
Scan Date	**10-31-10**			**SDL**
CRL Measure 1	**56**	**mm**		**SDL**
NT	**2.2**			**SDL**
PAPP-A				**SDL**

Thank you for submitting the first sample for the Sequential Maternal Screen. The first-trimester risk is below the screen positive cut-off (Down syndrome risk cut-off 1 in 50). The risk calculation will incorporate a history of a prior pregnancy with Down Syndrome or Trisomy 18 when provided. For a complete risk assessment, please send a second sample between 15,0 and 22,6 (weeks,days) gestation as measured by CRL. If a second sample is not received, the test will be reported as uninterpretable.

Down Syndrome Screen Risk Estimate		**SDL**

*** PERFORMING SITE**

SDL	Mayo Clinic Dpt of Lab Med & Pathology Superior Dr 3050 Superior Dr. NW Rochester, MN 55901	Lab Director: Franklin R. Cockerill, III, M.D.

PATIENT NAME	ORDER STATUS	COLLECTION DATE AND TIME
TEST409, 409	Final	12/20/10 12:01 P

Specimen receipt and report times are in CST/CDT

REPRINT