CLINICAL PATHOLOGY LABORATORIES
A Sonic Healthcare Clinical Laboratory

Maternal Recalculation Form

Please indicate which test is to be updated

☐ **MAFP** (#2617) ☐ **Quad Screen** (#5375) ☐ **First Screen** (#2616)

Cutoff for MAFP, QUAD: (**14w-21w6d**) Cutoff for First Screen: (**10w-13w 6d**)

Accession #:_____ Date:_____

Patient Name:_____ CSR name:_____

Physician office contact (Full Name):_____
(REQUIRED)

Phone number:_____ Fax number:_____

Note: Client is calling to provide information to recalculate risks. Gestational age typically is what they are calling to change based on new information gathered during sonogram, exam, or LMP.

1. What is the **GESTATIONAL AGE** based on? (**Choose one**. Ultrasound is most accurate)

☐ Gestational age on the day of the ultrasound:_____ Date of Ultrasound:_____

☐ Date of LMP:_____ (First day of Last Menstrual Period)

☐ Gestational age on day of Exam:_____ Date of Physical Exam:_____

☐ Estimated Date of Delivery (EDD):_____ Based on: ☐ LMP ☐ Ultrasound ☐ Physical Exam

2. **Miscellaneous changes**:

Maternal DOB: _____ Maternal Weight:_____lbs.

In Vitro Fertilization (IVF) used: ☐ Yes ☐ No If Yes, was a Donor used? ☐ Yes ☐ No

Donor's Approximate Age: _____ Was Patient's egg frozen: ☐ Yes ☐ No How long? _____

Testing: ☐ Initial ☐ Repeat Neural Tube Defect History: ☐ Yes ☐ No

Number of Fetuses: _____ If twins: ☐ Dichorionic ☐ Monochorionic

Current Smoker: ☐ Yes ☐ No Pre-existing Insulin Dependent DM: ☐ Yes ☐ No

Maternal Race: ☐ White ☐ Hispanic ☐ African American ☐ Other: _____

Austin Customer Service:

1. Print "P" report and attach to form.
2. Make copy of form for scanning and forward to scanning.
3. Scan the paperwork to the Special Chemistry Department using the "Dist Maternal Recalc/HX Forms" email group.

Regional Offices:

1. Print "P" report and attach to form.
2. Fax paperwork to Austin Customer Service Department at 512-873-5003.

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Patient History for Maternal Serum Screening

IVF Addendum:

Patient Name: _____ Accession #_____
Patient DOB: _____

The patient history states that IVF was used. As such, there are some added questions we will need answered in order to accurately assess the risk calculations. Was an egg donor used or is it a self-donation?

If **NO DONOR** was used:
Was the egg frozen at all? Yes/No
If yes, for how long (years/months)? _____

The bench will dial back the maternal DOB to reflect the time the ovum spent in cryostasis, in order to provide more accurate risk reporting.

If **A DONOR WAS** used:

For **MSAFP for NTD (2617)**:
Donor information needed:
Race _____ Family History of ONTD Y/N

For **1STSCREEN/QUAD testing (5375)**:
Donor DOB _____ or Donor Approximate Age _____
Race _____ Family History of ONTD Y/N

If there was a donor, the information needed is test dependent. MSAFP for NTD testing is not maternal age dependent. For QUAD testing, we will need an approximate age or DOB for the egg donor to reflect a more accurate maternal age as the prior risk of DS applies to the age of the donor if the egg or embryo is from a donation. Regardless of testing, if available, the Donor race and family history of NTD will affect risk reporting.

Please provide the requested information and fax the completed form to 512-684-3001 for prompt risk calculation and interpretation using complete data. Call the Prenatal Screen bench at 512-498-2146 for further questions.