Avera McKennan Regional Laboratory

Sioux Falls Service Center

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Sioux Falls SD 57117
605.322.7187 or 800.560.4846
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Maternal Alpha-Fetoprotein Form

Patient Name: _____ ***Soc Sec #*** _____
Last Name ***First Name***

Referring Facility: _____ ***Specimen Collection Date/Time:*** _____

Referring Physician: _____ ***Telephone:*** _____

Maternal Birthdate: (Must be birthDATE, not age or EDD) ____ / ____ / _____

Expected Date of Delivery (EDD) ____ / ____ / _____

Maternal Weight _____ ***kg*** ~or~ _____ ***lbs***

Please complete – *NOT* ***necessary for Amniotic Fluid Testing***

Circle appropriate response

Race _____

# of Fetuses _____

Yes / No ***Insulin Dependent Diabetic***

Yes / No ***Family history of neural tube defects. If yes, relative to fetus:*** _____

Yes / No ***Is this an In vitro fertilization pregnancy?***

If yes, age of egg donor _____

Yes / No / Unknown ***Has the patient taken valproic acid or carbamazepine (Tegretol) during this pregnancy?***

GESTATIONAL AGE CALCULATION: 15-22 weeks only

NOTE: Amniotic fluid specimens are acceptable from 13-30 weeks gestation.

Complete <u>at least one</u> of the following:

Gestational age by ultrasound (US): _____ ***weeks*** ____ ***days on date*** ____ / ____ / _____

Last menstrual period (LMP) date: ____ / ____ / _____

Gestational age by physical exam: _____ ***weeks on date*** ____ / ____ / _____